Medicaid Program Evaluation

Working Paper

MPE 4.2a February, 1987

MICHIGAN'S PHYSICIAN PRIMARY SPONSOR PLAN: IMPLEMENTING PRIMARY CARE CASE MANAGEMENT IN MEDICAID
VOLUME II ATTACHMENTS

James Bell
Helen Rosenthal
Larry Beyna

James Bell Associates, Inc.

Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations

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PREFACE

The Medicaid program, which finances health care for over 20 million needy Americans, has undergone major changes since 1981. Beginning with the Omnibus Budget Reconciliation Act of 1981 (OBRA), Congress gave the states much more flexibility to change basic parameters of the program, including which groups of people are served, what services are provided, how doctors, hospitals, and nursing homes are paid, and how care can be organized in innovative ways.

The Medicaid Program Evaluation addresses the implementation and impact of selected changes in the Medicaid program to provide knowledge for policy assessment and future legislative change. It is focused on selected issues and policy questions raised by recent legislation:

- o Federal Financial Participation
- o Inpatient Hospital Reimbursement
- o Eligibility
- o Case Management
- o Home and Community-Based Waiver Program
- o Cost-Sharing
- o Financial Incentives for Family Care
- o Medicare DRG Effects on Medicaid and
- o Synthesis.

Together these studies are intended to describe how recent changes have been implemented, and analyze what their effects have been for program services and costs.

This paper provides a detailed description of the Michigan Primary Physician Sponsor Plan (PPSP), one of the first and largest Medicaid case management programs initiated under OBRA-authorized waivers of the freedom-of-choice requirement. It covers the PPSP's first three years of planning and implementation, including details about the program's design, involvement of providers and recipients, administration, and early impact on the accessibility, quality and costs of care under Medicaid.

The paper is divided into two Volumes. Volume I contains the full text of the report and Volume II contains eleven attachments, which include copies of documents and materials referenced in Volume I.

There are several other MPE Working Papers dealing with the subject of primary care case management. Working Paper 4.1 is a survey of all state activity -- in case management and other areas -- in response to OBRA's relaxation of the Medicaid freedom-of-choice requirement. Working Paper 4.3 provides a detailed case-study of Utah's Choice of Health Care Delivery Program, and 4.4 contains briefer case studies of initiatives in four other states, Kansas, Colorado, Nevada and Wisconsin. Working Paper 4.5 provides a synthesis of findings from all the Task 4 case studies, and 4.6 contains the results of a limited statistical analysis of Utah Medicaid claims data to assess case management's impact on utilization and expenditures.

Gerald Adler
Project Officer
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ACKNOWLEDGEMENTS

This case study report could not have been completed without the full and interested participation of the Michigan Department of Social Services (MDSS), particularly Agnes Mansour, Director, Paul Allen, former Director of the Medical Services Administration (MSA), Sally Hetrick, Project Director for PPSP, Vern Smith, Director of MSA's Bureau of Program Policy, Carol Weigel, Department Analyst for PPSP, and Kathy Sarb, Supervisor of the Wayne County Medicaid Sponsor Office. We are thankful also for the support of the MDSS Office of Planning, Budget, and Evaluation.

While many other Michiganers contributed, we are especially thankful to Sherry Wellman, representing the Michigan State Medical Society and Bill Fairgrieve and Judy Daltuva of the Michigan League for Human Services. Similarly, we are grateful to our colleagues in the Medicaid Program Evaluation for their advice, particularly Gerry Adler, from HCFA's Office of Research and Demonstrations, and Ed Neuschler, the National Governors' Association. We were fortunate to have the participation of Michael Hendricks, who provided useful advice and helped to organize the materials in the report. Finally, Mallory Garner and Rowena Gear skillfully typed the manuscript.

James Bell
Helen Rosenthal
Larry Beyna

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ACRONYMS USED IN THIS REPORT

CAP	Capitated Ambulatory Plan
FFS	Fee-for-service
HMO	Health Maintenance Organization
MAOPS	Michigan Association of Osteopathic Physicians and Surgeons
MDSS	Michigan Department of Social Services
MLHS	Michigan League for Human Services
MSA	Medical Services Administration
MSMS	Michigan State Medical Society
OBRA	Omnibus Budget Reconciliation Act of 1981
PCCM	Primary Care Case Management
PPSP	Physician Primary Sponsor Plan
TRO	Temporary Restraining Order
WCMS	Wayne County Medical Society

ATTACHMENT 1.1

Approved by The Council, MSMS, July 18, 1981

Approved by the Board of Trustees, MAOP&S, July 18, 1981

PHYSICIANS' PROPOSAL FOR UTILIZATION MANAGEMENT

An Alternative Reimbursement System Under The Michigan Medicaid Program

Michigan State Medical Society

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Chairman
MSMS Medicaid Liaison Committee

Michigan Association of
Osteopathic Physicians
& Surgeons

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PREFACE

This document is submitted by the Michigan State Medical Society and the Michigan Association of Osteopathic Physicians and Surgeons, Incorporated, in partial fulfillment of the assignment directed by the Michigan State Legislature and the Governor as conveyed by Public Act 35 of 1981 which contains the following language:

> Sec. 68. (1) In conjunction with associations representative of allopathic and osteopathic physicians and the house and senate appropriations subcommittees on social services, the department of social services shall develop, through negotiations, an alternative reimbursement system for physicians. Agenda for the negotiations shall include: (a) a case management "lock-in" approach; (b) a capitation mechanism; (c) a pre-paid comprehensive health maintenance organization approach; and (d) protocols for utilization management, but shall not exclude other utilization management methods of reimbursement. A report detailing this system shall be submitted for approval to the house and senate appropriations subcommittees on social services by August 1, 1981.
>
> (2) The additional $6,676,200.00 appropriated to physicians in section 1 shall be allocated as an incentive fee to providers participating in the alternative system.
>
> (3) The change required in subsection (1) shall be implemented by October 1, 1981. If the department of social services has not reached agreement with providers by August 1, 1981, the department, with the concurrence of the house and senate appropriations subcommittees on social services, shall proceed toward implementation of a revised reimbursement system by October 1, 1981.[1]

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PROCEDURES

May 20, 1981 morning	Meeting at Medical Services Administration with MSMS Medicaid Liaison Committee, MAOP&S Medicaid Liaison Committee, legislative representatives and other interested parties
May 20, 1981 afternoon	Meeting at MSMS of MSMS Medicaid Liaison Committee and MAOP&S Medicaid Liaison Committee
June 2, 1981 morning	Meeting at MSMS of Ad Hoc MSMS/MAOP&S Medicaid Task Force
June 2, 1981 afternoon	Meeting at MSMS of MSMS Medicaid Liaison Committee, MAOP&S Medicaid Liaison Committee, Medical Services Administration, legislative representatives and other interested parties and consultants
June 24, 1981 all day	Meeting at MSMS of Ad Hoc MSMS/MAOP&S Medicaid Task Force
July 1, 1981	Completion of working draft proposal
July 7, 1981	Meeting at MAOP&S of Ad Hoc MSMS/MAOP&S Medicaid Task Force to review working draft proposal
July 8, 1981	Completion of second working draft proposal
July 9, 1981	Meeting at MSMS of MSMS Medicaid Liaison Committee, MAOP&S Medicaid Liaison Committee, Medical Services Administration, legislative representatives and other interested parties and consultants to discuss second working draft proposal Reactions to proposal from MDSS and legislative representatives
July 18, 1981	Approval of the proposal by The Council, MSMS
July 18, 1981	Approval of the proposal by the Board of Trustees, MAOP&S
August 1, 1981	Submission of physicians' proposal to the Legislature

MICHIGAN STATE MEDICAL SOCIETY

120 WEST SAGINAW STREET, EAST LANSING, MICHIGAN 48823, PHONE AREA CODE 517 337-1351

SPECIAL REPORT TO THE COUNCIL

Medicaid Liaison Committee
Allen F. Turcke, MD, Chairman

July 18, 1981

RECOMMENDATION: THAT THE COUNCIL RATIFY THE PROPOSED ALTERNATIVE REIMBURSEMENT SYSTEM FOR THE MICHIGAN MEDICAID PROGRAM.

Attached is the "Physicians' Proposal for Utilization Management", an alternative reimbursement system for the Michigan Medicaid Program, developed by the joint Medicaid Task Force of the Michigan State Medical Society and Michigan Association of Osteopathic Physicians and Surgeons. The proposal was developed pursuant to Section 68 (1) of Public Act 35 of 1981, which is the appropriations bill for the Department of Social Services, and attempts to encompass the directives of the MSMS House of Delegates Resolution of May 2, 1981 (pages 9, 10, and 11.)

Page iv details the procedures through which the proposal was forged. Pages 12 and 13 contain the proposal itself.

At the same time the MSMS Council is considering this proposal for endorsement, the MAOP&S Board of Directors will be taking similar action.

Initial responses from both the Legislature and the Department of Social Services have been positive.

Legislative leaders, specifically Senator Steven Monsma and Representative David Hollister, respectively chairmen of the Senate and House subcommittees on Medicaid, have spoken favorably of the proposal. Both verbally applauded the creativity of the plan, and are prepared to enter into talks of how to implement it.

Department of Social Services leadership likewise found the plan, in verbal response, positive and ambitious. Medicaid personnel express cautious support, then cite the mechanical difficulties of putting it in place even on a simulated basis. However, despite such precautions, DSS is prepared to enter into talks on implementation if the MSMS Council and MAOP&S Board ratify the proposal.

Legislative date for authority to proceed further is August 1, 1981.

Members of the Committee are: John W. Coles, MD; Thomas M. Flake, MD; James D. Johnston, MD; Cecil R. Jonas, MD; Henry A. Kallet, MD; Gerald H. Mandell, MD; Robert J. Toteff, MD.

COUNCIL ACTION: The Council, MSMS, on 7-18-81 received this report with thanks and approved the Recommendation.

PRESENTIMENTS

"It occurred to me that most of us are quite good at identifying the things that bug us. We call them problems. We shine bright lights all over and through them. We make charts and diagrams. We dissect them into their tiniest parts. We magnify them into mountains, and then we stand back in awe of the mountains....

What we don't do is think about how to get around, over or under the mountains. We sigh. We curse fate and other people supposedly responsible for our problems. We get ulcers. And we waste a lot of time and energy.

A problem is only a problem if it can be solved, fully or in part. .... If there is no solution, the trouble is definitely not a problem. It falls into some other category to be dealt with accordingly.

It may be an enigma. It may be a tough break. Maybe it's a tragic circumstance. Whatever it is, it is. If there are no available solutions, no change is possible. Ergo: The trouble demands acceptance. Simple. Only schizophrenics and other crazies cannot accommodate reality. Most of us aren't crazy.

We tend to be lazy, however. After we have dissected and diagnosed our problems, we just don't try very hard to find solutions. We focus on what's wrong instead of on what we can do to make things better. Sometimes, even when we have thought about possible solutions and found one or two that might help, we abandon them because they would require too much courage or energy to implement. Grumbling about a problem requires very little courage or energy.

Whether or not a solution is found to a particularly vexing problem, just the exercise of focusing on solutions rather than problems is quite creative....[2]

THE PROBLEM

Anyone reading this document, voluntarily or by assignment, could probably write a twenty page paper describing "The Michigan Medicaid Problem." The facts on the State's rate of unemployment, declining revenues, rising caseloads, increased costs of health care, budget cut-backs, cost containment proposals, etc., etc., have been well documented elsewhere and need not be repeated here. From the perspective of Michigan's physicians, the problem can be summarized quite simply: The State of Michigan can no longer afford the medical benefit package it has promised its Medicaid recipients.

The problem is not a new one. Nor are the solutions which have been offered in the past. That is not to say that well-meaning and intelligent people have not tried. We believe Michigan, in particular, has devoted more efforts attempting to control the Medicaid problem since the mid-1970's than a majority of her sister states. We also believe that all private sector parties involved in the Medicaid dilemma have made honest efforts to be a part of the solution to the problem rather than part of the problem. However, despite our mutual efforts, the Michigan Medicaid program appears to be in worse shape than ever. One of the major culprits cited for our mutual failure to solve the problem has always been "those Federal regulations" which prohibit innovative ideas from being tried without going through elaborate requests for "waivers" from the regulations.

Thus, when Michigan has been faced with fiscal shortages which necessitate economic cuts in the Medicaid program, the options have often been limited by those Federal regulations. Michigan physicians were bewildered in December of 1975 when Governor Milliken announced that as part of the solution to the fiscal problem, physician billings would be discounted by 11 percent beginning January 1, 1976. Physicians rendering care to Medicaid recipients were not aware that they were part of the problem, but they were being directed to be part of the solution. Again, in December of 1980, physicians' reimbursements were cut an average of 10 percent. However, because certain primary care procedure codes were exempted, many physicians experienced cuts in the range of 18 to 20 percent. Physicians again wondered why they were part of the problem given the fact that the physician line item in the annual appropriations bills had been adhered to consistently by the medical community.

In response to such inquiries, physicians were informed by members of the Michigan Legislature and the Michigan Department of Social Services that they had to make the necessary cuts in those areas permitted under the Federal regulations. Our attention was carefully directed to the relevant regulations which stipulate that "States are required by law to reimburse for inpatient hospital services on the basis of 'reasonable cost'...." while for physician services "the only requirement is that the State Medicaid reimbursement may not exceed the amounts paid under Medicare. While there is an effective ceiling on payment, there is no

corresponding floor."[3]

As this information filtered through the physician community in 1975 and 1976, several physicians expressed astonishment over the disparity in reimbursement policies and legal action was considered. The Michigan State Medical Society contracted with an independent legal research organization to determine if there were sufficient grounds for litigation based on unequal Medicaid reimbursement policies and practices. The report duly submitted to MSMS was well written and well documented, but the final answer amounted to: "No. Save your money and attempt other approaches to obtaining fair Medicaid reimbursements for physicians."

In December of 1976, the disparity between current Medicaid reimbursements and current Medicare screens was 27 per cent. During this period of time, Michigan legislators began receiving calls from their constituents on Medicaid regarding the inability to find a physician willing to accept them as new patients. There was also a significant number of physicians who simply "quit" Medicaid. Availability and accessibility of cost-effective physician services became another Medicaid problem. This part of "The Michigan Medicaid Problem" story is also familiar to readers of this document, but one that appears to be forgotten readily by some.

It should be remembered that most Medicaid patients did not go without medical care during this period of low physician participation in the Medicaid program. They did receive care, but in settings such as hospital

emergency rooms and "high volume" Medicaid clinics which cost the Medicaid program an average of three times the amount it would have for an average visit to a physician's office.

Availability of cost-effective physician care became a joint goal of physicians, the Legislature and MDSS during discussions in 1977. The outcome for that fiscal year was to encourage physicians to reopen their doors to Medicaid patients by increasing reimbursements to 1976 Medicare screens for ambulatory services. The actual boilerplate language read: "On October 1, 1977, the department shall increase fee screens for all physicians' services provided in an ambulatory setting to current medicare levels."[4]

The most important item to be remembered is that the plan worked. In July, MSMS began an active campaign to inform physicians that Medicaid reimbursements would be increased in October. Physicians did respond by increasing their willingness to accept Medicaid patients. In mid-December of 1977, the U. S. Department of Health, Education, and Welfare, through its Health Care Financing Administration's Institute for Medicaid Management, called a conference for health care providers and government officials designed to share information and ideas on how a partnership between Medicaid and providers could be forged.

The conference opened with a panel presentation which was to serve as an example of an effective, existing Medicaid partnership: Michigan. Participants included representatives from the Bureau of Medical Assistance of the Michigan Department of Social Services, the Michigan Hospital

Association and the Michigan State Medical Society. In explaining why Michigan had been chosen, Elsie M. Tytla, MD, medical advisor at the Health Care Financing Administration noted:

> "The purpose of the conference is to use the lessons of some states. When Medicaid officials work with providers solutions can be reached. The Michigan State Medical Society offered a workable suggestion for directing patients away from hospital emergency rooms to physicians' offices for non-emergency problems.
>
> The Michigan legislature saw the merit of the suggestion and enacted legislation to foster it. There's no question that substantial savings have been realized."[5]

Unfortunately, the great partnership was short-lived; it ended in 1979. By the time of the legislative discussions in 1979 over Medicaid appropriations, the final language which emerged said, "It is the goal of the legislature to achieve physician reimbursement rates at current medicare levels." [6]

This brings us to mid-summer of 1981. Physicians fees under Medicaid have not been increased since 1977 and they were cut an additional 10 per cent in December. It should be noted that the economic burden has been recently extended to include Medicaid recipients. The total effect of the cuts and the failure to update fees has not gone unnoticed by physicians. The Department of Social Services is also aware of the disparity in current reimbursements. Vernon K. Smith, Ph.D., director of the Bureau of Medicaid Information and Policy Development for the Medical Services Administration within MDSS, was recently quoted on the issue.

> "Smith said there can be no further cuts in payments to physicians since these already have been trimmed to 55 per cent of what those same doctors are paid for treating the elderly under Medicare.

> He said new Medicaid recipients are having difficulties finding doctors willing to accept them as patients outside of the so-called 'Medicaid mills.'"[7]

Welfare recipients benefits were cut by 5 per cent for the month of June and legislators and budget officials have recently agreed to continue the cut through the month of July. Efforts to continue the welfare reductions could result in a major political battle because, in the opinion of Rep. David Hollister, chairman of the Social Services Subcommittee of the House Appropriations Committee, "Michigan's poor families shouldn't have to bear further burden for the state's deficit 'when no one else is taking a cut,' he said."[8]

Michigan physicians have a hard time understanding why they are consistently identified as the major culprit in "The Michigan Medicaid Problem" when they have continually been asked to make the greatest financial contribution to the solution.

Nonetheless, the Michigan Legislature in considering the 1980-81 appropriations for MDSS, again requested physician assistance in developing solutions to the problem. However, this time the requests for solutions (made to both physicians and hospitals) were premised on the anticipation that the Reagan Administration would eliminate many of the Federal regulations which had stifled alternative approaches to reimbursement policies and cost containment in Medicaid programs.

The Michigan State Medical Society and the Michigan Association of Osteopathic Physicians and Surgeons, Incorporated wish to reiterate their belief that the physician line item for Medicaid reimbursements has not been

the major problem in Michigan. The two associations do, however, accept the challenge of working toward alternative reimbursement systems and reshaping the Medicaid program. The solution which is presented in this document is not a drastic one. Neither is it intended to replace existing innovations, such as HMO capitation arrangements and the Recipient Monitoring Program. It is presented as an "alternative" to be conducted on a pilot, demonstration basis in order that viable comparisons can be made.

PHYSICIANS' PERSPECTIVES

At the 1981 annual meeting of the Michigan State Medical Society House of Delegates, considerable deliberation was given to the Medicaid program and the problems it poses for physicians. As usual, there were several resolutions submitted to the House dealing with Medicaid. The reference committee which considered them reported to the full House that the resolutions categorically deplored the current physician reimbursement elements of the Medicaid program. The resolutions all alleged inequity, loss of quality, abuses by patients as well as some physicians, the imposition of economic hardship on physicians who see Medicaid patients, and lack of sensitivity of physicians' problems by both the legislative branch of government and the executive branch. Several of the resolutions propose specific responses to the government through MSMS actions. Discussion of the problem emphasized the following:

1. That there is unfair distribution of Medicaid dollars among physicians, hospitals, clinics and other health delivery institutions.
2. That the current Medicaid reimbursement levels cause many physicians to lose money by treating Medicaid patients.
3. That physicians in general, but not in every instance, will adhere to their ethical responsibilities and provide treatment for Medicaid patients.
4. That, conversely, Medicaid patients tend to abuse and overuse the system with excess demands and failure to follow doctors' recommendations.
5. That the public perceives doctors as being economically able

to care for Medicaid patients at whatever amount of reimburse- the government provides. Additionally, the public does not appreciate the inherent costs of operating a medical practice.

6. That in addition to the inequitable reimbursement by Medicaid, needless and excess paper work is foisted on doctors in order to receive any reimbursement at all.

Members of the reference committee were informed that this year's budget calls for negotiations among the Department of Social Services Bureau of Medical Services, the subcommittees on appropriations for social services of the Legislature, and MSMS and the Michigan Association of Osteopathic Physicians and Surgeons. They were informed that the first of these negotiations would take place in Lansing May 20. Doctor Allen Turcke of Flint, chairman of the MSMS Medicaid Liaison Committee, reported that he and his counterpart at MAOP&S, Doctor William G. Anderson of Detroit, had accepted the challenge to negotiate in search of acceptable reimbursement systems for Medicaid.

Because all the several resolutions had common themes which were the unfairness of Medicaid, the willingness of physicians to provide services even when returns are unfair, and the desire for MSMS to deal with the government to develop alternative means of reimbursing physicians, the reference committee offered a substitute resolution. The substitute resolution was officially adopted by the MSMS House of Delegates on May 2, 1981 and reads as follows:

"Whereas, the government has promised the poor and the medically indigent medical services equal and obtainable by private patients,

but never has provided reimbursement to physicians equal to reimbursement by private patients; and

"Whereas, the public and the government fail to comprehend and account for the high overhead costs associated with the delivery of medical care, and that physician income is generated only when reimbursement pays for those services as billed just as industry and commerce generate a profit only when overhead costs are considered; and

"Whereas, the Michigan State Medical Society stands on the ethical principle that all people, rich and poor, shall receive quality medical care; and

"Whereas, negotiations are beginning involving the Legislature, the Department of Social Services and physicians in search of an alternative reimbursement system for Medicaids; and

"Whereas, patient responsibilities to the Medicaid system should include, but are not present, an economic investment through copay or deductibles, adherence to physician recommendations, and discouragement of abuse of the system; now therefore be it

"RESOLVED: That the MSMS House of Delegates directs the Medicaid Liaison Committee to seek the following results:

1. A program that creates an environment wherein the Medicaid patient can receive medical care of a quality equal to other medical patients;

2. A program that encourages the state to better distribute its Medicaid monies so that practicing physicians are reimbrused commensurate with the reimbursement they receive for other patients;

3. A program that encourages use of the most economically effective and efficient medical treatment when that treatment is equal;

4. A program that tightens eligibility requirements so that only those seriously in need benefit from the Medicaid system;

5. A program that encourages both patient and provider responsibility in the utilization and the payment for medical services; and be it further

"RESOLVED: That MSMS generate a public information program this Summer that will inform the public of the costs of maintaining a medical practice; and be it further

"RESOLVED: That this House of Delegates expresses its full and unqualified support and confidence in the Medicaid negotiating team as it enters upon its challenging and difficult task; and be it further

"RESOLVED: That this resolution and pertinent portions of the discussion be communicated widely among members of the Michigan State Medical Society."[9]

A PROPOSAL

"Physicians' Proposal for Utilization Management"

1. Medicaid eligibles shall select a primary sponsor (control physician or provider) of choice, provided the sponsor agrees to accept the recipient. Either party wishing to terminate the arrangement may do so upon reasonable notice and for justifiable cause. (To be defined.) The Department of Social Services shall notify each primary sponsor of his/her/its assigned patients for the coming month no later than three days prior to the beginning of said month.

2. Medicaid eligibles shall be given 60 days from the beginning of the enrollment period to voluntarily select their primary sponsor. A plan shall be developed jointly by MDSS, MAOP&S and MSMS for enrolling eligibles who have not selected a primary sponsor after 60 days.

3. In recognition of the additional services required of the primary sponsor (continuous responsibility, accessibility, the process of control, preauthorization of services, cost constraints), incentive administrative fees shall be authorized. The actual amount and process by which it is rendered to the primary sponsor shall be the subject of additional discussions among MDSS, MAOP&S and MSMS.

4. Each physician contact by the recipient shall be paid on a fee-for-service basis structured to discourage over utilization. Examples of incentives shall be:

a. Parity reimbursements for ambulatory services regardless of setting. In particular, total reimbursement for hospital freestanding clinic services shall not exceed comparable office based services.

b. Higher reimbursement for office based surgical procedures.

5. All physicians enrolled as participating physicians in the Medicaid program shall be eligible for participation in this program. MDSS should monitor primary sponsors enrolled in this program and clarify its authority to act expeditiously to disenroll any physician abusing the program.

6. This program is recommended on a pilot basis. Targeted areas shall contain a significant Medicaid population and participating physicians so as to obtain a representative cross section of sick and healthy eligibles.

The next section contains certain particulars of the above proposal. We recognize, however, that input from the Department of Social Services is necessary in order to more completely describe the administrative and technical aspects of this approach.

PARTICULARS AND PRIORITIES

The MSMS/MAOP&S task force has identified several priority issues which must be considered a part of the Physicians' Proposal for Utilization Management. Indeed, we believe they must be considered regardless of whether this or another approach is taken toward an alternative reimbursement system for Medicaid.

1. Educational Responsibilities. Medicaid recipients must be informed, in plain language, that their medical benefit package is threatened by the State's economic plight. This should be the responsibility of MDSS.

   Physicians must be informed that sufficient participation in the recipient lock-in plan is necessary to determine its potential effectiveness. This is the responsibility of MSMS and MAOP&S.

2. Parity of Medicaid with Medicare. Ideally, physicians should receive the same reimbursement for services rendered regardless of the source of payment, i.e., private, Blues, Aetna, HMO, or the government. Realistically, Michigan physicians have only asked that two government programs (Medicare and Medicaid) designed to assist our elderly, disabled, and our poor be equitable in reimbursements. The only possible reason Medicaid physician participation has not been drastically reduced since December is that physicians are aware of the State's economic situation and are attempting to absorb their fair share of the necessary budgetary cuts.

The question is how long physicians can continue to exist with the disparity between Medicaid and Medicare? The disparity in 1976, when the State approached a crisis situation in physician participation in Medicaid, was 27 percent. Now, in mid-1981, Medicaid payments are 45 percent lower than Medicare levels. This disparity will increase after July 1 when Medicare screens are traditionally updated to reflect the previous year's data. To phrase the situation another way: assume a physician's regular charges are paid by private-pay or other insurance at 100 percent; Medicare usually reimburses at 75 percent of charges; now Medicaid reimburses at 55 percent of Medicare. Physicians are asking that Medicare screens be used as the minimum standard.

3. Primary Sponsor. Under the proposal, a primary sponsor shall accept the full responsibility for rendering or authorizing all care for that Medicaid recipient. The primary sponsor would have to arrange coverage arrangements with another physician while absent from the community. A pharmacy could only fill a prescription on the primary sponsor's authorization. An emergency room would have to receive authorization from the primary sponsor prior to rendering non-emergent care.

A primary sponsor could be an individual physician, a group practice, a clinic, or an institution. The setting must be one which the recipient has chosen and which has control of the patient chart. In a clinic setting for example, a recipient may request services and be

seen by alternate physicians, but the chart would serve to indicate whether duplicate or unnecessary services would result.

The Department of Social Services should carefully monitor all primary sponsors. Where costs are considered excessive, recipients should be directed to other sponsors for diagnosis and treatment. Note: This redirection of services is a difficult problem. MDSS, the participating physicians and other sponsors must recognize the problems inherent in distinguishing between utilization vs. over utilization, quality vs. quantity and the dilemma of health care rationing. We must work together in good faith to neither abuse the patients nor the system. We also should not be constrained by rules and regulations that interfer with our collective best judgment in directing recipients for appropriate care.

4. Referral Care Authorized by Primary Sponsor. In addition to the requirement that all referral care be authorized by the primary sponsor, MDSS should provide the primary sponsor with a list of all referral services received by each recipient in his/her/its control. Frequency of reports can be determined in cooperation with MDSS analysis of ability to generate reports. The referral care reports would serve as an informational/educational vehicle for the primary sponsor.

5. Office Based Surgical Procedures. The MSMS/MAOP&S task force strongly believes that physicians should be encouraged to perform selected surgical procedures in the least expensive setting. We recognize that this concept has been accepted and implemented, to a limited extent, in

differential reimbursements for in-patient and out-patient settings. Now we believe it is time to go another step in order to decrease the facility costs associated with traditional out-patient/ambulatory procedures conducted in institutional settings.

The Department of Social Services, in conjunction with physician associations, PSROs, and others have developed a tentative list of selected procedures which could serve as the basis for discussion. Careful analysis of appropriate procedures would be required along with estimates of reasonable costs to physicians in recognition of additional equipment, personnel and facility changes which may be necessary to assure quality of care. Since office based surgery would eliminate costs generated by out-patient surgeries (surgical suite costs, recovery room costs and fixed-day costs) we recommend a 25 percent increased fee above updated screens for those procedures when they are done in the physician's private office.

6. Reimbursement for Primary Sponsor Responsibilities. The MSMS/MAOP&S task force devoted many hours in an attempt to develop equitable financial recognition of the additional responsibilities that will be required of a primary sponsor. In addition to the medical responsibilities, i.e., 24-hour accessibility, there will certainly be additional administrative costs incurred i.e., referral authorization forms.

The approach recommended by the task force is a fixed fee paid to the primary sponsor per assigned Medicaid eligible per month. Suggestions have ranged from $3.00 to $7.00 per month. This administrative service fee would recognize those situations where the primary sponsor exercises

control of recipient care although an actual physician/patient encounter may not occur, i.e., telephone calls authorizing or refusing referral care, refusing emergency room services at night for non-emergent conditions.

The MSMS/MAOP&S task force has not reached a decision on the most appropriate financial incentive to recognize the additional responsibilities of a primary sponsor. We realize the incentive funds identified by the Legislature amount to only $6 million and our first priority is to update Medicaid screens. However, if the proposal eliminates duplicative physician services and decreases emergency room visits, an equitable administrative fee does not seem unreasonable. Additionally, since the proposal is recommended for targeted areas on a demonstration basis, the number of eligibles/administrative fees will be significantly less than if it were a statewide program.

7. "Lock-In" is Necessary for Recipient Overutilizers. The MDSS methodology for currently identifying Medicaid recipients who overutilize the program has been transmitted to MSMS and MAOP&S, but needs further explanation, clarification and simplification. The criteria used to define "over-utilization" need to be tightened or lowered, i.e., using 60 scripts per month as the threshold for pharmacy overutilization seems rather high.

After more appropriate criteria are developed for identifying recipient overutilizers, recipients so identified should be required to obtain a primary sponsor. They would have choice of sponsor and the sponsor

would have a choice of acceptance. We would recommend for this particular group of recipients that the primary sponsor be a private practitioner in conjunction with a specific pharmacy.

8. Fraud and Abuse Activities. Although it has been stated before by both MSMS and MAOP&S, the task force wishes to reiterate its strong support for MDSS activities to identify suspected cases of physician abuse of the Medicaid program and to instigate administrative sanctions against those with demonstrated patterns of abuse. If problems exist with the recent legislation (PA 321 of 1980) designed to strengthen the Department's ability in this regard, they should be brought to our attention so appropriate amendments can be sought.

9. Retention of Fee-For-Service. The MSMS/MAOP&S task force seriously considered other ideas brought to its attention by MDSS and other interested parties. We cannot agree to a "capitation" for the entire Medicaid program. That approach is being used in several models at the current time and can be used for future comparisons with the proposed fee-for-service "lock-in" approach presented herein.

10. Pilot Projects in Different Geographical Areas. The task force recommends that the proposal be used as a demonstration project in more than one area to account for differing population characteristics. For example, perhaps Wayne County, Bay County and Muskegon County would offer interesting comparisons. Information on how the program affected utilization in each of the sites would need to be carefully monitored and reported for meaningful comparisons.

11. "Key" to the Lock. The task force believes it is important to guarantee an equitable process whereby eligibles and sponsors alike can terminate the lock-in agreement. The "key" must be reasonable for the MDSS to administer and provide timely notices to all parties. Regardless of the final process developed, it must assure that requests for reassignment are not based solely on the basis of race, color, creed, marital status, sex, national origin, residence, age, or handicap.

PURPOSE AND PROJECTIONS

The purpose of the Physicians' Proposal for Utilization Management is to conduct an experimental alternative reimbursement system for physicians under Medicaid through an approach which locks in recipients with a primary sponsor. It should be a pilot project in a significant geographical area containing a significant number of Medicaid eligibles representing a cross section of healthy and sick recipients and a significant number of enrolled physicians. The pilot program should have a defined trial period to enable comparisons to be drawn among the existing reimbursement systems.

The proposal is designed to determine whether the Michigan Medicaid program can experience financial savings through reductions in hospital costs and in physician service duplications using a physician/patient "lock-in."

We believe this proposal complements the goals of the Michigan Hospital Association's plan to reduce hospital utilization by approximately 12.6% at an anticipated savings of $35 million. We are unable to estimate cost-savings from our proposal until the scope of the pilot areas has been determined. It should be noted that projected cost-savings cannot be derived simply from the physician line item account because all other medical services accounts will be affected. We project savings not only in physician utilization, but in hospital admissions, hospital utilization, pharmaceutical services, emergency room utilization for non-emergent care, and

non-emergent ambulance utilization.

We sincerely hope and believe that our proposal will be cost-effective. But, and more importantly, we hope that the prime consideration will be whether quality medical care is delivered to the Medicaid population of our State. If cost considerations outweigh quality of medical care, then it is our opinion that many people have labored in search of a short-term solution without looking at the long-term problem.

PROPOSALS FOR LONG RANGE SOLUTIONS

The proposals made in the previous section will only be effective in the long run if certain additional changes are made in the Medicaid program. These changes are viewed as major structural modifications in the program and are too extensive to be accomplished within the time limits imposed by the present legislation. They should be viewed as forming the basis of future discussion between MSMS, MAOP&S, the Michigan Department of Social Services and the Legislature.

From the physician perspective, these structural changes are necessary because those programs which only focus on provider reimbursement have a very limited potential for creating real, permanent cost savings.

The MSMS/MAOP&S task force would like to make the following suggestions for topics to be discussed in the future:

a. Instead of budgeting by provider class e.g. physicians, hospital, pharmacy, the Medicaid program should be budgeted by recipient programs viz. AFDC, SSI, and medically needy.

b. Prioritizing the type of benefits paid for under the program.

c. Defining and limiting the benefits offered under the Medicaid program.

1. <u>Change the basis of budgeting from the providers of service to the recipient program classification</u>. The Medicaid program has at least three distinct groups of recipients, the AFDC and general assistance population, those individuals receiving supplemental security income

aid from the federal government and the medically needy. Each of these groups have separate medical needs and utilization characteristics. By placing them all under the single line item of Medicaid and then making allocation by medical provider, the potential for cost saving in any one program is obscured. Additionally, by budgeting in this manner it becomes much easier to blame the providers of services for the financial shortfalls.

From the information supplied to the task force by the MDSS, amount of per recipient benefit increased very little between 1974 and 1979 ($622 to $641) (see table #2) in CONSTANT DOLLARS. The real problem facing the Legislature is inflation and the need to control the apparent increase in dollars allocated to the Medicaid program. The physicians of the State recognize this as a very difficult situation, but one over which they have very little control. By continuously reducing the fees paid to providers, the Legislature is only avoiding the public policy decision of how to allocate resources to needy groups within our society during times of extreme inflation.

In order to focus on this problem, it is apparent at some point public policy must consider the relative merits of limiting services to certain types of individuals to insure every individual in need will receive at least adequate medical care.

A second benefit to identifying each group separately within the Medicaid program will be the ability to create specific cost containment programs suitable to the medical needs of these groups.

Data from the MDSS and other sources indicates substantial difference between the utilization pattern of the AFDC population as compared to the medically needy group. The AFDC group is very similar to the general population in use and intensity of service and possibly programs such as pre-payment or indemnification could be used to cover this population. However, the data indicates the medically needy recipients are individuals with extensive need for medical care. Many individuals in this group are permanent institutionalized patients, and would require completely different and creative types of cost containment programs.

.2. Prioritizing the types of benefits offered. The federal government requires a state Medicaid program to provide for payment to hospitals and physicians in order to be eligible for matching funds. Along with these services the states have the option of covering additional types of services (see chart #1). It is not our intention to discuss the relative merits of offering these programs. We propose that the decision to offer these services be made each year and be dependent on the state's ability to pay for them adequately. If the Legislature believes it should make these programs available, then it must be prepared to fund them at a level approaching the actual value of the services.

When the State is not economically able to cover the expanded benefit categories, the Legislature, with the advice of the medical community, must determine which services will be of the most assistance to the recipient population and formulate policy accordingly.

3. Defining and limiting the benefits offered under the Medicaid program.

The Medicaid program in Michigan has been referred to as the best health insurance program available in the world today. The Legislature, with the assistance of the physicians, must determine which benefits are most necessary to maintain the health of the recipient population and determine the quantity of those services necessary to accomplish this goal.

It is apparent as the program is presently structured, neither the providers of services nor the recipients have any real initiative to make decisions regarding the most effective utilization of services.

A number of states are presently studying proposals to bring the Medicaid coverage more in line with the commercial insurance or prepaid health plans available in their states.

It is our understanding the MDSS is currently studying several proposals from HMOs to cover Medicaid recipients and each of these proposals contain definite limits on certain services.

The Congress presently has before it several proposals containing provisions to limit the type and quantity of services available under the program. We recognize the concept of limiting the benefit package must be approached very cautiously. The basic provision of the Medicaid program is to provide for the medical needs of the poor. Unfortunately in today's economy this goal will be unattainable unless some system is developed to determine which benefits will have

the most impact on the health of the population and how much of each service can be made available to any particular recipient. The only alternative is to ration care based on the amount of dollars available regardless of how important some of these procedures are to the overall welfare of the individuals.

The limiting of services available to any one individual can not be taken lightly. There always exists the possibility that if limits are placed on the number of services a recipient may receive, we may be denying needed medical care. We are confident a suitable system can be designed to allow for catastrophic illness and the accompanying need for extensive utilization of services. This system can be designed in a way which would place the least burden on the recipient and the provider insuring the patient will receive medical care without interruption.

These three basic proposals plus specific ideas suggested earlier in this paper create the basis to begin developing permanent solutions to the cost of providing care to the Medicaid population. The task force feels any solution to the present difficulties must include both the specific short term adjustments to the program and the long term changes suggested in this section.

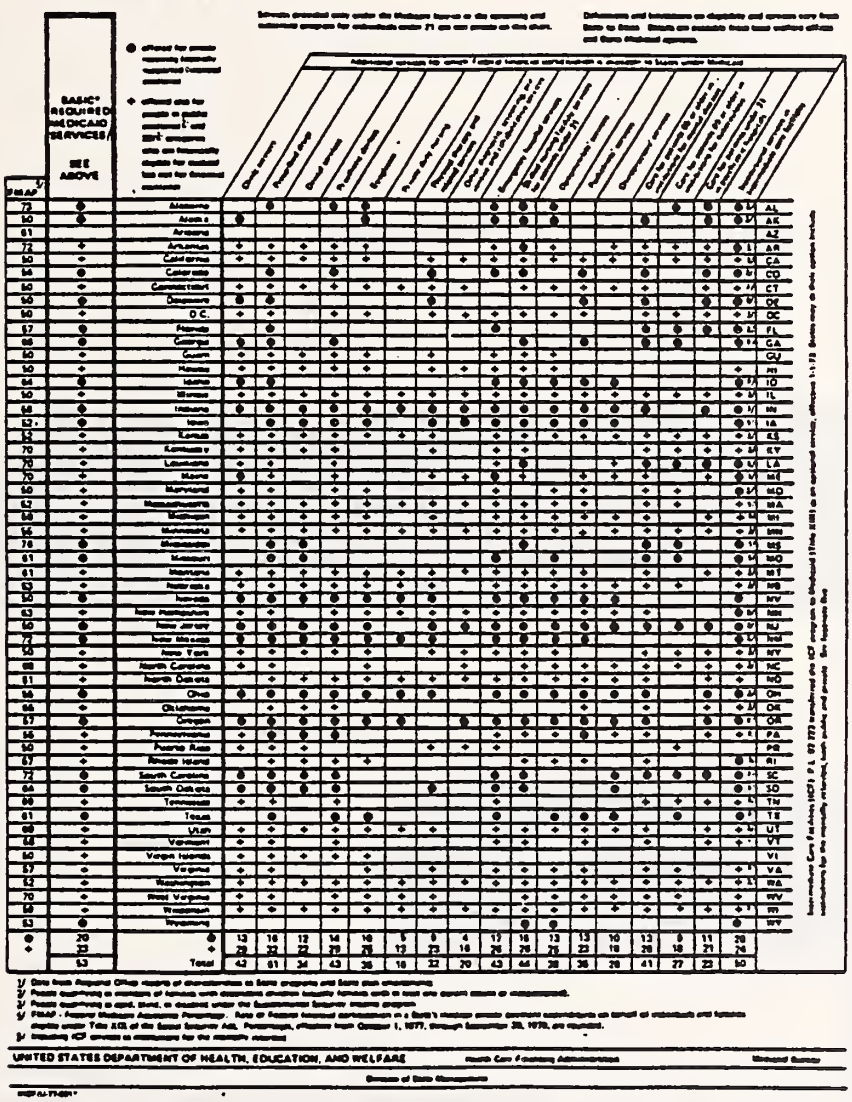
All of the above proposals must be addressed in order for MSMS and MAOP&S to feel confident in endorsing any plan eventually presented to the legislature by the MDSS.

We will offer the assistance of each of the associations in developing a time schedule to develop specific proposals to implement both the short and long term goals presented in this paper.

TABLE 1

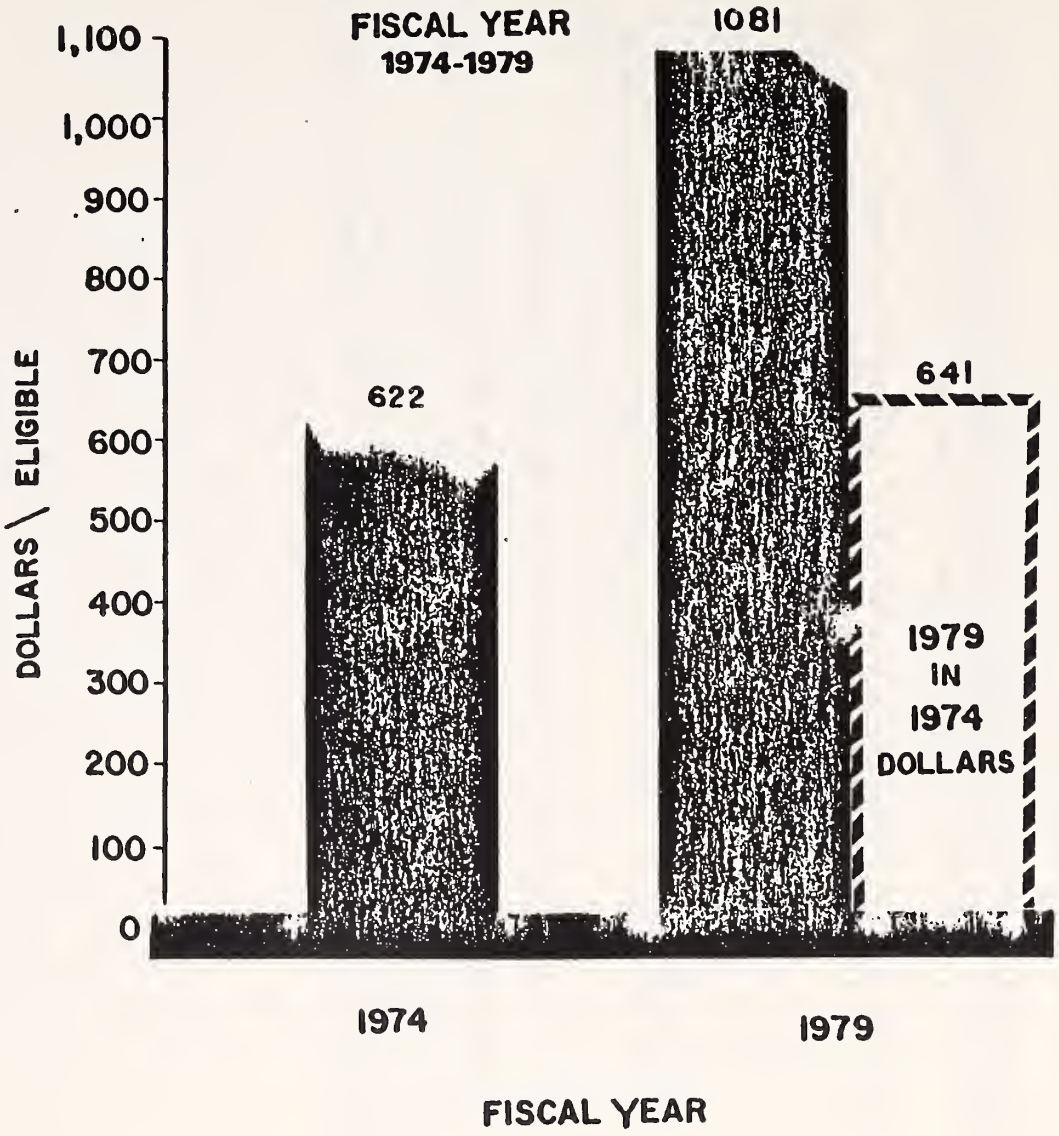
MEDICAID SERVICES STATE BY STATE,

DECEMBER 1, 1977 ✓



UNITED STATES DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

MA BENEFITS PER ELIGIBLE
MICHIGAN



FOOTNOTES

[1]State of Michigan, 81st Legislature, Regular Session of 1981, Enrolled House Bill No. 4130, Public Act 35 of 1981, Legislative Service Bureau, State Capitol, Lansing, Michigan.

[2]Excerpted from an article by Nickie McWhirter, "A Problem Isn't a Problem Unless There's a Solution," Detroit Free Press, June, 1981.

[3]Data on the Medicaid Program, Eligibility/Services/Expenditures, 1979 Edition, The Health Care Financing Administration, U. S. Department of Health, Education, and Welfare, Baltimore, Maryland 21235, p. 21.

[4]State of Michigan, 79th Legislature, Regular Session of 1977, Enrolled House Bill No. 4163, Public Act 103 of 1977, Legislative Service Bureau, State Capitol, Lansing, Michigan.

[5]"HEW Woos Physicians for Medicaid," American Medical News, January 3, 1978.

[6]State of Michigan, 80th Legislature, Regular Session of 1979, Enrolled House Bill No. 4187, Public Act 110 of 1979, Legislative Service Bureau, State Capitol, Lansing, Michigan.

[7]"Hospitals Plan Cuts to the Poor," The Detroit News, June 28, 1981.

[8]"State Welfare Aid Cuts Will Last Through July," The Detroit News, June 28, 1981.

[9]"Report of Reference Committee B," Michigan State Medical Society House of Delegates, May 2, 1981 (on file at MSMS Headquarters, East Lansing).

June 1. 1982

MEDICAL ASSISTANCE PROGRAM

PHYSICIAN PRIMARY SPONSOR PLAN CONTRACT

This contract is entered into this first day of July, 1982, effective upon implementation of the plan or the first of the month subsequent to a 2 week period after both parties have signed this agreement, whichever is later, with an expiration date of September 30, 1983, by and between the Michigan Department of Social Services, having a mailing address of 300 South Capitol Avenue, P.O. Box 30037, Lansing, Michigan 48909 (hereinafter referred to as the "Department") and _____ having a mailing address of:

_____

(herinafter referred to as the "Sponsor"). See Addendum B for further enrollment information relating to the sponsor's participation under this contract.

Witnesseth:

Whereas, the sponsor desires, upon entering this contract, to become a physician primary sponsor; and,

Whereas, the department, as the designated state agency to establish and administer the program of medical assistance for the medically indigent under title 19 of the federal social security act, being 42 U.S.C. §1396 et seq., is authorized to obtain physician's services for the benefit of recipients of that program; and

Whereas, the department has been authorized to establish and administer the medical assistance program pursuant to Act No. 280 of the Public Acts of 1939, as amended, being MCL §400.1 et seq.;

Now, therefore, in consideration of the agreements and mutual covenants herein contained, the parties hereto agree to the provisions contained in this contract.

A. Definitions

As used in this contract:

1. "Caseload" means those recipients for whose care the sponsor is responsible under this agreement.

2. "Costs" means all amounts paid by the department for claims submitted for inpatient hospital, outpatient hospital, physician, pharmacy, laboratory and radiology services rendered to recipients in the sponsor's caseload by the sponsor and other providers.

3. "Covered medical expenses" means those expenses related to inpatient and outpatient hospital services, physician services, clinical laboratory services, radiology services, and pharmacy services which are covered under the medical assistance program.

4. "Department" means the department of social services, including the Medical Services Administration which is charged with administering the provisions of this agreement.

5. "Fee-For-Service" means a method of Medicaid reimbursement which is based upon payment for services rendered to recipients subsequent to, and specifically for, the rendering of those services.

6. "Medical assistance program" means the department's program to provide for medical assistance established by section 105 of Act No. 280 of the Public Acts of 1939, as amended, being §400.105 of the Michigan Compiled Laws, and title 19 of the federal social security act, 42 U.S.C. §1396 et seq.

7. "Medical emergency" means any condition for which a delay in treatment may result in the recipient's death or the permanent impairment of the recipient's health.

8. "Patient type" means the number of recipients in a sponsor's caseload that fall into each of the 4 patient-type categories.

9. "Patient type category" means one of 4 categories determined by age and assistance program as set forth in Addendum A of this contract.

10. "Peer review advisory committee" means an entity comprised of professionals and experts who are selected by the department, nominated by an organization or association or organizations or associations representing a class of providers, and established pursuant to section 105(2) of Act No. 280 of the Public Acts of 1939, as amended.

11. "Primary care" means ongoing responsibility for the coordination of the medical care of the patient. The appropriate use of consultants and community resources is an important part of effective primary care. Health screening, administered under contract by local health departments as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is not considered primary care. Diagnosis and treatment services shall be considered primary care.

12. "Professional review" means review by professionals and experts who are selected by the department to review the medical necessity and appropriateness of services rendered in their area of expertise.

13. "Specialist" means a physician whose practice is limited to a particular branch of medicine or surgery, including one who, by virtue of advanced training, is certified by a specialty board as being qualified to so limit his practice.

3. The sponsor agrees:

1. To provide primary care to each patient in his or her caseload and to render services in accordance with the medical assistance program provider manual, any amendments, changes or additions thereto, and applicable state and federal laws and regulations.

2. To prior authorize all nonemergency care rendered by other physicians and hospitals for recipients in his or her caseload enrolled under this contract, except that sponsor authorization of vision services provided by ophthalmologists shall not be required under this contract.

3. To prior authorize all nonemergency pharmacy, laboratory, and radiology services.

4. That any authorization shall be in a form and manner specified by the department and developed pursuant to the consultation guidelines adopted by the department to implement section 111a of Act No. 280 of the Public Acts of 1939, as amended.

5. That a referral shall be made by the sponsor if the recipient requests a second medical opinion. After the second opinion has been obtained, any treatment received by the recipient shall be rendered by the sponsor or through referral by the sponsor.

6. That an authorization shall not be required for services rendered during a medical emergency.

7. That, after a sponsor's initial referral of a patient to a specialist for on-going treatment, the specialist will not be required to receive further specific authorizations for the duration of the illness or, at the sponsor's discretion, for a period of time specified by the sponsor. This shall include services rendered by the specialist and referrals for related services made by the specialist. If a recipient is an established patient of a specific specialist, the sponsor shall refer the recipient to that specialist whenever applicable to the patient's condition. The sponsor shall be responsible for the medical necessity of the initial referral to a specialist made by the sponsor. Determinations of medical necessity for the purpose of this paragraph shall be made by the department through professional review and after review by a peer review advisory committee. If community mental health service boards are involved in the treatment of a sponsor's patient, the sponsor should not interfere in the treatment. An automatic referral shall be made by the sponsor and costs will not be attributed to the sponsor.

8. To bill the department for all services rendered by him or her under this contract within 6 months of the date the service was provided.

9. To provide or arrange for coverage 24 hours a day and 7 days a week. Failure to fulfill this responsibility may result in termination of this contract by the department.

10. To request the removal of a recipient from his or her caseload pursuant to procedures established by the department and developed pursuant to the consultation guidelines adopted by the department to implement section 111a of Act No. 280 of the Public Acts of 1939, as amended.

11. To notify the recipient of the sponsor's intention prior to the sponsor's submission of the request for a recipient's removal to the department.

12. Neither to accept a recipient nor request the removal of a recipient solely on the basis of age, race, creed, color, sex, physical or mental handicap, national origin, marital status, sexual preference, or type of illness or condition.

13. To accept recipients as assigned by the central or county office of the department, except as modified herein, up to the limit specified by the sponsor. The department will, to the extent possible without abrogating recipients' rights to free choice of sponsor, attempt to ensure that assignments result in an equitable case mix for each sponsor.

14. That the sponsor may inform any current patients who are recipients of the sponsor's participation in this plan.

15. That the department may limit the total number of recipients enrolled with a sponsor under this agreement to 1,500, that this limitation shall be the total for all the business locations of the sponsor, and that case management fees will only be paid by the department up to a maximum of $3,000 per month.

16. To review the reports on services rendered to recipients and notify the Medical Services Administration of any incorrect billings or billing for unauthorized care.

17. To transfer, at the request of the department or the recipient, a summary or a copy of a recipient's medical records to other sponsors or providers if the recipient changes sponsors.

18. That any appeal of any department actions taken under this contract will be in accordance with R 400.3401 et seq. of the Michigan Administrative Code and Act No. 280 of the Public Acts of 1939, as amended, after review by a peer review advisory committee, provided that any department action taken under paragraphs B(21), B(24), and C(4) of this contract may be immediately effective and shall continue in force pending the issuance of a final decision by the director following an administrative hearing, any provision of R 400.3401 et seq. of the Michigan Administrative Code or Act No. 280 of the Public Acts of 1939, as amended, to the contrary notwithstanding.

19. That any appeal of any department adverse actions taken under this contract other than those described in paragraph B(18) shall be in accordance with R 400.3401 et seq. of the Michigan Administrative Code and Act No. 280 of the Public Acts of 1939, as amended, after review by a peer review advisory committee, provided that the department may immediately hold all case management fees in escrow pending the issuance of a final decision by the director following an administrative hearing, any provision of R 400.3401 et seq. of the Michigan Administrative Code or Act No. 280 of the Public Acts of 1939, as amended, to the contrary notwithstanding.

20. That the department may remove a recipient who appears to be misutilizing medical services from a sponsor's caseload and may enroll the recipient in a program to control utilization pursuant to procedures set forth in R 400.7391 to R 400.7397 of the Michigan Administrative Code.

21. That if the department determines that the sponsor has exceeded utilization measures in use by the department for physician, pharmacy, laboratory, or radiology services, either by separate category or in total during a period of time covered by this contract, any case management fees paid to the sponsor during the period of time the sponsor has been found to have exceeded the department's utilization measures shall be recovered by the department by withholding, suspending, or adjusting payments, or by other appropriate means. For the purposes of this clause, a departmental determination of overutilization shall be any or all of the following: a) a determination of overutilization by a peer review advisory committee, b) an adverse action related to overutilization taken pursuant to R 400.3401 et seq. of the Michigan Administrative Code, and after review by a peer review advisory committee or, c) an emergency action taken pursuant to section 111f of Act No. 280 of the Public Acts of 1939, as amended.

22. That the department may determine the physicians who are eligible to participate under the plan pursuant to the cost-effectiveness criteria set forth in paragraph C(4) and Addendum A of this contract.

23. To update any changes in information listed in Addendum B within 30 days of the changes. The most recent copy of Addendum B submitted by the sponsor shall automatically become part of this contract, superseding the Addendum B being amended.

24.* To participate in the plan with the following conditions: a) the case management fee shall be held in escrow and, b) if the sponsor meets the cost standards established by the department pursuant to Addendum A of this contract for each of the first three quarters of the contract year, the funds held in escrow plus interest for each of the quarters shall be delivered to the sponsor according to the following schedule:

Quarter	Funds Delivered
1st	11 months after beginning of contract year
2nd	14 months after beginning of contract year
3rd	17 months after beginning of contract year
4th	17 months after beginning of contract year

This schedule reflects a time lag consisting of both: a) the sponsor's six month billing requirement, and b) the earliest availability of claim processing reports to the department.

If the cost standards are not met for all of the first three quarters of the contract year, the sponsor shall be disenrolled from the plan and the funds held in escrow for the quarters for which the standards were not met and for all subsequent quarters shall revert to the department. A sponsor who does not meet the cost standards for the first quarter of the contract year shall not be eligible to be a sponsor after the end of the contract year. Application of the cost standards pursuant to this paragraph shall occur after consultation with a peer review advisory committee.

* Clause for "provisional" participation among physicians with a history of high utilization.

C. The department agrees:

1. To provide the sponsor with an initial list of the recipients for whose care the sponsor is responsible no later than the effective date of this contract and any revised list no later than the last day of the month preceding the month for which the changes in the caseload are effective.

2. That reimbursement for services rendered under this contract shall be in accordance with the department's existing fee-for-service arrangements under the medical assistance program except as modified herein.

3. To pay the sponsor, at a minimum, a monthly case management fee of $3.00 for each recipient enrolled with the provider pursuant to this contract not to exceed $3,000.00 per month, except as modified herein and elsewhere in this contract. The fee for a particular month shall be paid at the end of the month. The fee may be revised annually at the discretion of the legislature and/or the department, upon consultation with affected providers, to reflect the savings realized under the plan. Changes in the case management fee shall be effective on the first day of the month subsequent to the announcement of the change.

4. To determine the physicians who are eligible to participate under the plan pursuant to the following standard:

   Any sponsor who, personally or through referrals, exceeds the 95th percentile of costs for inpatient hospital, outpatient hospital, physician, pharmacy, laboratory and radiology services, either by separate category or in total, for their recipient population for a 3 month period, appropriately adjusted for case mix and caseload size, may, at the option of the department and after review by a peer review advisory committee:

   a. Be disenrolled from the plan and this contract shall be terminated.

   b. Remain enrolled in the plan but lose their case management fee or receive a reduced case management fee. A sponsor affected by this clause may be reinstated to normal status if the department determines, after reviewing claims data from the subsequent 3 month period, that the sponsor has dropped below the 95th percentile of costs. Such reinstatement shall occur no sooner than the third quarter following the quarter for which the high costs were incurred, at which time, the case management fee shall be paid retroactively for the intervening quarters during which management was appropriate. Sponsors who exceed the 95th percentile for 3 out of 4 consecutive quarters shall not be eligible for normal status until an additional 4 quarters have passed.

   Calculations and determinations made by the department for the purposes of this clause shall be made quarterly and shall conform to the methodology set forth in Addendum A of this contract. Recipients who are enrolled with a sponsor affected by section C(4)(a) of this clause shall be enrolled with another sponsor and copies of medical records or summaries of medical records pertaining to those recipients shall be transferred to the new sponsor.

5. To provide the sponsor with legible, accurate and intelligible reports of the medical services and expenses incurred for each recipient enrolled with the sponsor under this contract. The content of the reports shall be established by the department in consultation with the peer review advisory committee.

6. Pursuant to procedures and criteria established by the department in accordance with paragraph D(9) of this contract, to remove a recipient from the sponsor's caseload at the sponsor's or recipient's request no later than the first day of the month that follows a maximum period of 6 weeks subsequent to the department's receipt of the sponsor's or recipient's request.

7. To provide the sponsor with timely notification of any amendments, changes, or additions to the medical assistance program provider manuals.

D. The sponsor and the department agree:

1. That this contract contains all the terms and conditions agreed upon by the parties.

2. That this contract is coterminous with the medical assistance program provider manuals and with the Medicaid provider enrollment forms. All rights, duties, and responsibilities contained therein still apply.

3. That, except for amendments required as a result of a change in federal or state law or regulations beyond the control of the department, the department shall develop amendments to this contract after consultation with affected providers. The sponsor agrees, upon the request of the department and receipt of the proposed amendment so developed, to amend this agreement. If the sponsor refuses to sign such amendment within 60 days after receipt, this contract shall terminate upon the 61st day after receipt.

4. That this contract, including the rights, benefits or duties hereunder, shall not be assigned, in whole or in part, either directly or indirectly, by either party. This clause shall not be construed to forbid the sponsor from arranging for coverage for recipients during the sponsor's vacation or other off-duty hours.

5. That this contract shall terminate upon the death, retirement, bankruptcy, or insolvency of the sponsor or the sale of the practice of the sponsor who has signed this contract.

6. That this contract shall terminate if the physician primary sponsor plan, which this contract implements, is terminated by the department or the legislature.

7. That this contract shall be terminated by the department if the sponsor is convicted of fraud or if an action is sustained for abuse related to the programs established by title 18 or 19 of the federal social security act or related to reimbursement by any other health care insurer, or if an adverse action is taken by the department related to abusive practices and is accomplished pursuant to state law or R 400.3401 to R 400.3425 of the Michigan Administrative Code after review by a peer review advisory committee. Any case management fees paid to a sponsor during the period during which fraud or abuse related to the medical assistance program occurred shall be recovered by the department by withholding, suspending, or adjusting payments, or by other appropriate means.

8. That this contract may be terminated, with or without cause, at any time, upon 60 days notice in writing delivered by certified mail or in person by the sponsor or the department.

9. That amendments to this contract and to the medical assistance program practitioner manual shall be accomplished after consultation with

affected providers pursuant to the guidelines adopted by the department to implement section 111a of Act No. 280 of the Public Acts of 1939, as amended. This clause shall also apply to those provisions in this contract which reference procedures and criteria to be established by the department.

10. That the case management fee shall be contingent upon funds appropriated by the state and federal legislatures. If such funds are not appropriated, this contract may, in the discretion of the department, be terminated as of the last day of the last month for which such funds were available.

11. That the sponsor shall indemnify, save and hold harmless the department against any and all expense and liability of any kind which the department may sustain, incur or be required to pay arising out of the willful or negligent acts of the sponsor; provided, however, that the provisions of this paragraph shall not apply to liabilities or expenses caused by or resulting from the willful or negligent acts or omissions of the department or any of its officers or employees, or to actions taken or omitted, decisions made or omitted, or care rendered or omitted by physicians, organizations or any persons other than the sponsor. Further, in the event the sponsor becomes involved in or is threatened with litigation the sponsor shall make all reasonable efforts to notify the department and the department may enter into such litigation to protect the interests of the department as they appear.

12. That the department may terminate this contract upon fifteen days notice if the name of the sponsor, or the name of a subcontractor, manufacturer, or supplier of the sponsor, subsequently appears in the register compiled pursuant to section 2 of Act No. 278 of the Public Acts of 1980. This act prohibits the state from entering into contracts with certain employers who engage in unfair labor practices; prohibits those employers from entering into certain contracts with others; provides for the compilation and distribution of a register of those employers; and provides for the voiding of certain contracts.

E. We, the undersigned, do hereby agree to the terms and conditions contained in this contract.

Signatures: _____ _____

Paul M. Allen
Director
Medical Services Administration

(Sponsor)

Dates: _____ _____

ADDENDUM A

Methodology for Calculating Sponsor Cost Standards

Average costs for each sponsor's enrolled recipients will be reviewed periodically and, after adjustment for patient types, compared with those of other sponsors. Those providers with costs in any single category (inpatient hospital, outpatient hospital, physician, pharmacy, laboratory, and radiology) or in total exceeding ninety-five percent of all Group B and Group C sponsors may be dropped from the sponsorship program or have their sponsorship fee eliminated or reduced.

Reviews will take place on a quarterly basis, after allowing a reasonable time for claims to be submitted. For the purposes of this contract, "reasonable" shall mean that period of time during which at least 90% of all Medicaid claims for a category of services (as described above) are submitted and paid. This period of time shall also include the date of service. Sponsors will be divided into three groups:

Group A - fewer than 100 enrolled recipients
Group B - 100 to 1,000 enrolled recipients
Group C - more than 1,000 enrolled recipients

A new random sample of 250 sponsors in Group B will be selected each quarter. Average costs for each service category for these sampled sponsors and all sponsors in Group C will be computed. Thus, sponsors with a large number of enrolled recipients will be monitored every quarter. Sponsors with a moderate number of enrolled recipients will be monitored during random quarters. Sponsors with a small number of enrolled recipients will be monitored as resources permit. Average costs will be computed for each of these patient types:

Type	Eligibility	Age
I	ADC	0-20
II	ADC	21+
III	SSI	0-20
IV	SSI	21+

In addition, the fraction of patients in all reviewed sponsors' caseloads falling in each type will be computed. Each of these fractions will be multiplied by the sponsor's average costs for that recipient type and the products added. This sum is a standardized average cost per sponsored recipient per quarter. This process must be repeated for each service category, with the total of these products providing a standardized average total cost per sponsored recipient per quarter. When a sponsor has fewer than 5 enrolled recipients of a particular type, the county-wide average cost for that type will be used in the calculation of adjusted total costs.

These standardized averages may then be used to estimate the ninety-fifth percentile for each category and for total costs. Any sponsor in any of Groups A, B and C exceeding this percentile may, at the option of the department and following the procedure described in this paragraph, be dropped from the sponsorship program or receive a reduced sponsorship fee, retroactive to the beginning of the reviewed quarter and continuing until all standardized costs fall below the ninety-fifth percentile. A claim detail report will be printed for all

sponsors who exceed the ninety-fifth percentile for any category or for total costs. The report will be analyzed by departmental staff and a recommended course of action will be included in a written report. If the recommendation is to reduce or place in escrow the case management fee, or to disenroll the sponsor from the sponsor plan, the claim detail report and recommendations will undergo professional review and review by a peer review advisory committee. Recommendations resulting from professional review and the peer review advisory committee, will be considered by the department prior to taking action pursuant to this paragraph.

Sponsors dropped from the sponsorship program may be reinstated after one year with the agreement of both parties.

ADDENDUM B

Sponsor Enrollment Information

Please provide the following information. If any of this information changes, you must send a revised signed copy of this page to the Provider Enrollment Unit, Medicaid Information Division within 30 days of the change.

1. Physician's name, telephone number, and main mailing address where contracts, sponsor bulletins, and general information should be sent.

   Name: _____

   Address: _____
   Number Street & P.O. Box (if any)

   _____
   City State Zip Code Phone No.

2. Indicate the addresses of each location where the physician will be practicing medicine as a primary sponsor (include clinic or group name if appropriate). If affiliated with a hospital outpatient department, either salaried or independent, state the hospital's name and the clinic name. Contact MSA Provider Enrollment if a new ID number is needed. Sponsors must have a separate ID number for each location at which they will provide services. Indicate below the Medicaid ID number and telephone number for each location. (NOTE: This telephone number will be printed on the recipient's Medicaid ID card. It must be a 24-hour access number.)

Location	Location
Telephone No. (for 24-hour access)	Telephone No. (for 24-hour access)
Medicaid ID Number	Medicaid ID Number
Location	Location
Telephone No. (for 24-hour access)	Telephone No. (for 24-hour access)
Medicaid ID Number	Medicaid ID Number

Physician's Signature (must be original)

Revised 1/83

ADDENDUM C

Amendments Effective on October 5, 1982

By order of the Wayne County Circuit Court in Case No. 82-225, 143-CK, the following amendments have been made to the Physician Primary Sponsor Plan contract:

1. Paragraph B(15) is modified to read:

> That the department may limit the total number of recipients enrolled with a sponsor under this agreement to 2,000, that this limitation shall be the total for all the business locations of the sponsor, and that case management fees will only be paid by the department up to a maximum of $3,000 per month. The 2,000 maximum may be exceeded in situations where existing physician/patient relationships would be interfered with or where members of a sponsored recipient's family wish to enroll with the same sponsor. Nothing in this paragraph shall be construed to allow a recipient to be enrolled with more than one sponsor.

2. Paragraph B(18) is modified to read:

> That any appeal of any department actions taken under this contract will be in accordance with R 400.3401 et seq. of the Michigan Administrative Code and Act No. 280 of the Public Acts of 1939, as amended, after review by a peer review advisory committee. Pursuant to the Wayne County Circuit Court order, no adverse action taken under this contract shall become final until a decision rendered after a hearing if timely requested by the provider, provided, however, that the department reserves the right to amend or retract this amendatory paragraph in accordance with any further orders of the Circuit Court in Wayne County Circuit Court Case No. 82-225, 143-CK. This contract shall not be construed as a waiver by the sponsor of his rights under the Michigan Administrative Procedures Act, the federal Medicaid statute, Act No. 321 of the Public Acts of 1980, or the Michigan and United States Constitutions.

3. Paragraph B(19) is deleted.

ATTACHMENT 2.1

CASEWORKER SEMINAR

Physician Primary Sponsor Plan
February 15 & 17, 1984

I. Introduction.....Sally Hetrick

II. Background.....Sally Hetrick

III. Enrollment Options.....Carol Weigel

IV. Sponsor Contract/Major Client Issues.....Carol Weigel

V. Enrollment Form.....Sally Hetrick

VI. Monitoring Project.....Celeste Rabaut

Medicaid Enrollment Options
Wayne County Demonstration Project

In an effort to contain Medicaid costs while maintaining the current levels of service, a pilot project has been initiated in Wayne County. Medicaid recipients are offered three options in medical care and must select one. All three options involve enrollment with a provider. Once the recipient selects an enrollment option, a level of care code is put on CIS and the Medicaid card will reflect the plan chosen. Once enrolled, the recipient will receive additional information specific to the option selected.

The options are as follows:

1. The Physician Primary Sponsor Plan (PPSP), aka Medicaid Sponsor Plan. Under the sponsor plan, recipients select a sponsor doctor. Different family members may choose different sponsors. The sponsor's name and phone number will appear on the Medicaid card. Sponsors either directly provide or authorize primary care services. Recipients do not need sponsor authorization for emergency care (although they should call if possible), ear and most eye services, dental, family planning services in a family planning clinic chiropractic or podiatric services. Recipients in a long term care facility may not enroll.

   The prescription copayment will not apply for recipients enrolled with a sponsor beginning 2/1/84.

   The PPSP is a case management approach. The sponsor doctor (usually a general or family practitioner, a peditrician, an internist or an obstetrician/gynecologist) acts as a gatekeeper thereby reducing inappropriate physician visits and duplication of services. With one doctor responsible for the overall care, better continuity of care is expected as is a shift from more expensive hospital care to care in the physician office.

   There are about 1,100 doctors signed up for the sponsor plan. Most doctors do sign up after the program is explained to them.

2. Health Maintenance Organizations (HMOs). HMOs have been enrolling Medicaid recipients for over ten years. Recipients who elect HMO enrollment must enroll as a case unit but may select individual doctors within the HMO. The name and phone number of the HMO selected will appear on the "dental only" Medicaid card issued to the client. The HMO is responsible for all services except dental and personal care. Recipients in a long term care setting or active in a community mental health program may not enroll.

   Compared to the fee-for-service system, the HMO program saves money for the state. The fee paid to the HMO is about 10% less than the average per person fee-for-service payment. HMOs accomplish this savings by emphasizing preventive medicine and, to the extent possible, rendering care in the least expensive setting (e.g., in the physician office instead of the hospital outpatient setting). The HMOs offer a standard benefit package to all enrollees, Medicaid and private pay. Recipients will receive additional services (such as nutritional counseling) which are not normally Medicaid covered services if they elect HMO enrollment. None of the HMOs currently under contract charge copayments.

There are six HMOs with multiple locations in the Detroit area. Beginning 1/1/84, the six month enrollment lock-in has been eliminated. Recipients will be "locked-in" to any of the options only as long as it takes to administratively effect a change (usually two to six weeks).

3. Clinic Plan. The clinic plan was developed using the HMO philosophy for the much smaller clinic setting. As with the HMO, case enrollment is required. From the recipient's perspective there is little to distinguish the clinic plan from either HMO or PPSP enrollment although clinic plan may offer additional services (such as routine check-ups or copayment elimination) as enrollment incentives. The major difference is internal - the method the Medical Services Administration uses to pay.

   There are two clinic plans in Wayne County with five locations. Care must be taken to distinguish the two clinic plans from general medical clinics. Recipients should check with their clinic if in doubt. For ease of enrollment processing, the enrollment form (DSS-1336) asks recipients to write down an HMO or the name of their doctor. If the doctor is part of a clinic plan, the recipient will be enrolled in the clinic plan.

All completed forms are sent to the Medical Services Administration in Lansing for processing. The forms will be sorted into those which require follow-up and those which can be immediately coded and enrolled on CIS. Follow-ups will be required if the provider requested is not participating or if inadequate information is provided. It is very important that a phone number for the recipient be recorded on the form.

Physician Primary Sponsor Plan Training

The Sponsor Contract - Major Client Issues

. . .

Objectives

1. To acquaint the participants in a general way with the contract DSS signs with physicians under the Sponsor Plan with special attention paid to provisions that DSS offices are most likely to be impacted by. These include provisions related to:

   a. The responsibility of the sponsor to provide or authorize all primary care to recipients in his or her caseload.

   b. The sponsor's responsibility to authorize nonemergency care provided by other providers.

   c. Recipient requests for second medical opinions.

   d. The handling of medical emergencies.

   e. Referrals for specialty services.

   f. 24-hour availability of the sponsor.

   g. The assignment of clients to, and the removal of clients from, a sponsor's caseload.

   h. Medical service utilization reports received by the sponsor.

   i. Case management fees received by sponsors.

2. To give the participants experience in analyzing day-to-day "cases" which may occur. The analyses will be done using the contract as background material.

Form DSS-1336. Completion Instructions.

The Medicaid Enrollment Request for Wayne County, Form DSS-1336, should be used at intake and redetermination for ADC cases. Enrollment with a physician sponsor, a Health Maintenance Organization (HMO) or a Clinic Plan is mandatory for ADC recipients in Wayne County. Other noninstitutionalized clients with Medicaid eligibility may elect to enroll.

Caseworkers should:

1. Include form DSS-1336, Medicaid Enrollment Request for Wayne County, with intake or redetermination materials for ADC clients unless a level of care code appears on the DSS-5a. Exception: Clients with a level of care code 88 should be given the form.

2. Collect the form and assure that it has been completed during the intake or redetermination interview. It is important that the client indicate the full name and address of the provider (many doctors have more than one location). If the client does not have a physician, HMO or Clinic Plan, write NONE in the space provided. If the client refuses to complete the form, write REFUSES TO COMPLETE on the form. Advise the client that an assignment to a physician, an HMO or a Clinic Plan will result.

3. Advise clients that upon enrollment they will receive information which explains the program. If an enrollment cannot be made with the provider the client indicates, no enrollment will be made until the client is contacted and asked about a second choice. It is important to indicate a phone number where the client can be reached.

4. Forward completed forms via ID mail to: Department of Social Services, Medical Services Administration, Physician Primary Sponsor Plan, Lansing. One copy must be retained for the case file.

5. Refer clients who want detailed information about their choices or who would like to change their enrollment to the Medicaid Sponsor Office, 256-9344.

MEDICAID ENROLLMENT REQUEST FOR WAYNE COUNTY
Michigan Department of Social Services

Medicaid is offering three options in medical care for you and your family:

- a doctor under the Medicaid Sponsor Plan,
- a Health Maintenance Organization (HMO), or
- a clinic plan. Most clinics are NOT Clinic Plans. If your doctor is in a clinic, call the clinic to see if it is a Clinic Plan.

You choose which option you want to enroll in and complete the attached form. If you need more information on the three options call 256-9344. You must return the completed form to your caseworker.

The options are designed for you to go to one Sponsor Doctor, an HMO, or a Clinic Plan for most of your medical care.

- You do not have to go to your Sponsor Doctor for chiropractic, dental, family planning clinic, hearing, podiatric, and most vision services.
- You do not have to go to your HMO or Clinic Plan for dental services.

When you need medical care, you must call your Sponsor Doctor, HMO, or Clinic Plan. The name and telephone number of the Sponsor Doctor, HMO, or Clinic Plan will be printed on your Medicaid card.

If you need emergency treatment (for example, because you were in a car accident), and a delay in treatment could result in permanent harm or loss of life, you may go to the hospital emergency room. Since the name and telephone number of your Sponsor Doctor, HMO, or Clinic Plan will be on your Medicaid card, the hospital will call them, if necessary.

If you are unhappy with your Sponsor Doctor, you may change to another Sponsor Doctor, an HMO or Clinic Plan by calling the Medicaid Sponsor Office at 256-9344. If you are unhappy with your HMO or Clinic Plan, you must contact your HMO or Clinic Plan to disenroll. You will have to choose a Sponsor Doctor, another HMO, or another Clinic Plan.

SPECIAL NOTE:

If you enroll with a Sponsor Doctor you will receive more information from Medicaid about the Medicaid Sponsor Plan. If the doctor you chose is not enrolled as a Sponsor Doctor, Medicaid will contact you to select another doctor, an HMO or a Clinic Plan.

If you enroll in an HMO or Clinic Plan, the HMO or Clinic Plan will send you more information when you enroll.

FACSIMILE

Reproduced by the State of Michigan

MEDICAID ENROLLMENT REQUEST FOR WAYNE COUNTY

Michigan Department of Social Services

Case Name				
Case Number				Date
County	District	Unit	Worker	

FACSIMILE

INSTRUCTIONS:

- Under Medicaid, you must enroll in the Medicaid Sponsor Plan, an HMO, or a Clinic Plan for all your medical care. READ THE FRONT SHEET OF THIS FORM FOR INFORMATION ON ALL THREE PLANS. Call 256-9344 if you need more information.
- Your family may enroll with different doctors under the Medicaid Sponsor Plan.
- If you choose an HMO or a Clinic Plan, all family members must enroll in the same HMO or Clinic Plan.
- Complete Section I below if you want to enroll in the Medicaid Sponsor Plan or a Clinic Plan for your family's medical care, OR
- Complete Section II below if you want to enroll in an HMO for your family's medical care.
- It is very important that you enter each recipient ID Number from your Medicaid card. If you do not have a Medicaid card, leave the Medicaid ID Number box blank.
- After you complete this form sign your name below and return this form to your caseworker.

SECTION I: I want to enroll in the Medicaid Sponsor Plan or a Clinic Plan. If you go to a clinic, select a doctor from that clinic. Do NOT enter the clinic name.

List the Name(s) of Each Family Member (Last, First, Middle Initial)	Medicaid ID Number	List a Doctor for Each Family Member	DSS Use Only	Doctor's Address	DSS Use Only

SECTION II: I want to enroll in an HMO.

List the Name(s) of Each Family Member (Last, First, Middle Initial)	Medicaid ID Number	Enter the Name of the HMO	DSS Use Only	HMO Address	DSS Use Only

Client Address	Phone	SIGN HERE ▶ Client's Signature

DSS-1336 (10-83)

Caseworker: Send completed form in ID mail to: Physician Primary Sponsor Plan Office
Medical Services Administration
Department of Social Services

Produced by the State of Michigan

Physician Primary Sponsor Plan

SPONSOR CONTRACT
Small Group Exercise

Instructions: Training participants will be divided into groups and assigned two questions each. Using the contract provisions cited, answer each question to the best of your ability. Choose a group leader to explain the problem and your answers to the larger group. If the answer is not completely clear from the contract, give the probable correct answer and indicate what additional information you need.

1. A client receives medical care five times over a six month period. The first two times, the sponsor treats the client for a cold (the same cold). The third and fourth time the client is seen by the sponsor's business partner with the sponsor's authorization. These services relate to relatively minor complaints resulting in a few lab tests and one prescription. The fifth time the client is seen by the sponsor in the hospital for a one day stay relating to the minor complaints mentioned previously.

   Question: Did the sponsor comply with the primary care requirements of the contract? Why or why not? (See contract paragraphs A(11) and B(1).)

2. A client feels "under the weather" and goes to a physician near her home for treatment. This physician is not her sponsor but knows the physician who is. The physician received an authorization from that physician with regard to another patient and therefore knows the sponsor's ID number. The physician provides the service and bills Medicaid using the sponsor's ID number as the "referring/prescribing" physician.

   Question: Did the sponsor comply with the Sponsor Plan authorization requirements? Why or why not? (See contract paragraphs B(2), B(3), B(4), and B(6).)

3. A client has been diagnosed by her sponsor as having cancer. The sponsor is recommending a severe and radical treatment to begin immediately in hopes of catching the disease in time. The client is frightened about surgery and asks the sponsor if she could go to another physician for a second opinion. The sponsor considers herself a top-notch cancer specialist, refuses to make the referral, and tells the client that a finer cancer doctor is not available and that she (the sponsor) should be trusted.

   Question: Did the sponsor comply with the referral provisions of the contract? Why or why not? (See paragraphs A(13), B(5), and B(7).)

4. A client slips and falls in his home and a deep cut on the head results. The client goes to the emergency room for treatment. The admitting staff notices that the client has a sponsor and calls the sponsor for authorization. There is no answer to the call and the hospital has to decide how to proceed.

   Question: Should the hospital treat the patient and bill Medicaid? If so, how? (See paragraphs A(7), A(14), B(2), and B(6).)

5. A client goes to his sponsor for treatment of a skin condition. The doctor feels that a dermatologist could handle the situation better and makes a referral to one she knows. The treatment goes on for a few months and the sponsor finds out that the dermatologist is prescribing an unusually high number of prescriptions for the patient.

   Question: What should the sponsor do? (See paragraphs A(11), A(13), B(2), B(3), B(4), and B(7).)

6. A client feels ill at 2:00 in the morning and calls the sponsor number listed on the MA ID card. A recorded message comes on the line and says the doctor will be in the next day and to leave the name and number so that the doctor can get back with the patient. The tape then says that if the situation is a medical emergency, the patient should go to the emergency room for treatment.

   Question: Did the sponsor comply with the contract? Why or why not? (See paragraphs A(7), B(1), B(2), B(6), B(9), and Addendum B.)

7. A client calls her caseworker and complains that her sponsor is trying to "drop" her from the sponsor's caseload. The sponsor told the client that she was going to do that and subsequently notified the department as well.

   Question: Is the sponsor behaving properly? Why or why not? (See paragraphs B(10), B(11), B(12), B(13), and C(6).)

8. Dr. Jones has about a hundred recipients in his caseload and recently received five "utilization reports" from DSS on five clients who utilized quite a few medical services. Jones reviewed the reports and got very concerned about the behavior of these patients. The next time each patient visited Dr. Jones, they received a lecture from him and a copy of the utilization report. The clients all call the caseworker and ask what they should do.

   Question: Did the sponsor act appropriately? Why or why not? (See paragraphs B(1), B(2), B(3), B(16), and C(5).)

9. Dr. Smith has 400 Medicaid patients in her Sponsor Plan caseload. She calls DSS in Lansing to complain that the $1,200 check she receives every month is not adequate to pay for all the services she provides.

   Question: What should the DSS spokesperson reply to Dr. Smith? (See paragraphs B(15), C(2), C(3), and C(4).)

10. A client complains to his caseworker that the sponsor to which he was recently assigned is refusing to treat the client. The sponsor's reason is that the client has the reputation of being a drug addict and the sponsor is trying hard to build a "clean" practice.

    Question: Is the sponsor's behavior appropriate under the contract? Why or why not? (See paragraphs B(1), B(10), B(12), and B(13).)

EVALUATION

PPSP Training Session

Please help us evaluate this training session. Circle the appropriate response to each question.

1. The information was presented clearly and in a well-organized manner.

1	2	3	4	5
strongly agree	agree somewhat	agree	disagree somewhat	strongly disagree

2. This information will be helpful to me in working with clients

1	2	3	4	5
strongly agree	agree somewhat	agree	disagree somewhat	strongly disagree

3. There was sufficient information given.

1	2	3	4	5
strongly agree	agree somewhat	agree	disagree somewhat	strongly disagree

4. There was sufficient time to ask questions.

1	2	3	4	5
strongly agree	agree somewhat	agree	disagree somewhat	strongly disagree

5. What changes would you suggest in the presentation to make it more helpful to you?

-OVER-

6. What other information about the PPSP, HMO, and Clinic Plan options would be helpful to you?

7. Any other comments?

ATTACHMENT 2.3
MDSS COMMUNICATIONS TO RECIPIENTS

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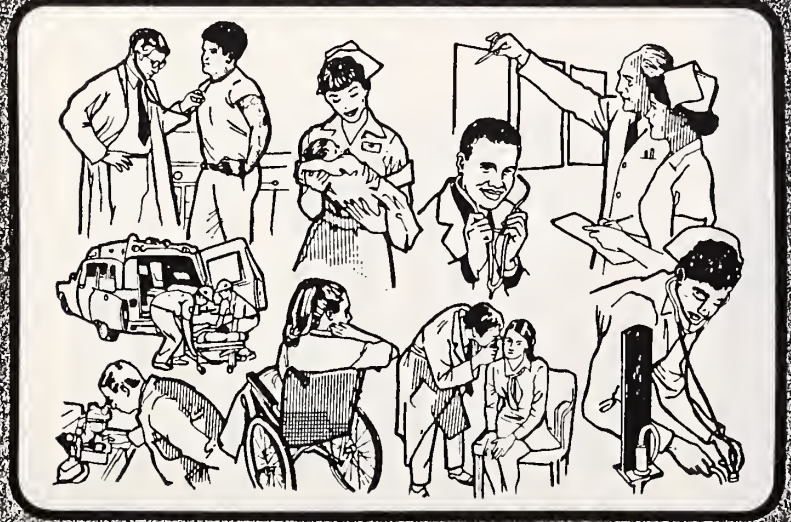
tatus,

MICHIGAN
DEPARTMENT OF SOCIAL SERVICES
North End P.O. Box 02040
Detroit, Michigan 48202

BULK RATE
U. S. POSTAGE
PAID
Detroit, Michigan
Permit No. 18

DSS Publication 524 (4-82)

Medicaid Sponsor Plan



To have Medicaid you must choose one DOCTOR or an HMO for all your medical care. You must call the Medicaid sponsor number to tell us which DOCTOR or HMO you want to go to.

THE MEDICAID SPONSOR NUMBER IS

256-9344

A WAYNE COUNTY RECIPIENT MAY CALL COLLECT, IF NECESSARY

WRITE THE NUMBER DOWN BY YOUR TELEPHONE

READ THIS BOOKLET BEFORE YOU CALL

It tells you:

- how you sign up with your DOCTOR or HMO,
- how Medicaid can help you choose a DOCTOR or an HMO, and
- what you can expect under the Medicaid sponsor plan.

When you get this booklet, you must choose a DOCTOR or an HMO. You have 15 days to call the Medicaid sponsor number with your choice. If you do not call within 15 days, Medicaid will assign you to a DOCTOR or an HMO. The name and telephone number of the DOCTOR or HMO will be printed on your Medicaid Card. If you are not happy with the DOCTOR or HMO assigned to you, call the Medicaid sponsor number.

WHEN YOU CALL

You must:

- have your Medicaid Card in front of you.
- tell us your name and Medicaid ID Number.
- tell us which DOCTOR or HMO you want, or ask us to help you choose a DOCTOR or an HMO.

We will:

- enroll you (or sign you up) with the DOCTOR or an HMO.
- tell you the date you are enrolled with the DOCTOR or HMO of your choice.
- print the DOCTOR'S or HMO'S name and telephone number on your Medicaid Card.
- tell the DOCTOR or HMO when you will become their patient under the Medicaid sponsor plan.

All eligible family members will be enrolled at the same time. A family may choose different DOCTORS for different family members. If you choose an HMO you may select different doctors within the HMO.

MEDICAID CAN HELP YOU

We can tell you:

- which DOCTORS and HMOS will accept Medicaid recipients who are under the Medicaid sponsor plan.
- where the DOCTORS and HMOS are located.
- what an HMO is. (Very briefly, an HMO is an organized system of doctors and other health professionals which provide comprehensive and coordinated health care services to its enrolled members.)

We can also answer other questions you have about the Medicaid sponsor plan.

WHEN YOU NEED MEDICAL CARE

You must go to the same DOCTOR or HMO you have chosen for all your medical care. The name and telephone number will be on your Medicaid Card.

You do not have to go to this DOCTOR for vision, dental, podiatric and chiropractic services. You do not have to go to the HMO for dental services.

If you are under 21, you may go to an EPSDT clinic for Medicaid EPSDT services.

- If you require medical care (for example, open heart surgery) that your DOCTOR or HMO cannot provide, you will be sent to another DOCTOR for special care.

- You should always try to call your DOCTOR or HMO first in any medical emergency. They must have 24 hour service. If they cannot treat you in the office, they will tell you where to go for treatment. If you cannot call because a delay would cause lasting harm or loss of life, go to the hospital emergency room. The hospital will call your DOCTOR or HMO.

- You must show your Medicaid Card or HMO Card whenever seeking medical services.

- You must follow Medicaid rules, like getting a second opinion before Medicaid will pay for certain surgeries. Your DOCTOR or HMO can tell you which surgeries require a second opinion under Medicaid.

IF YOU ARE NOT HAPPY WITH YOUR MEDICAL CARE

You may ask Medicaid to change your DOCTOR or HMO. BUT FIRST,

- Talk to your DOCTOR or HMO about your medical care. Your DOCTOR or HMO needs to know how their treatment helps or doesn't help you.

- If you keep having problems (like you can't get in for care with your DOCTOR or HMO or you are not happy with your medical care) call the Medicaid sponsor number. We will help you solve the problem.

- You may also ask for another DOCTOR'S opinion about your care. Your DOCTOR or HMO must refer you for a second opinion.

Your DOCTOR or HMO cannot refuse to treat you because of your race, sex, religion, age, national origin, color, marital status, handicap, political beliefs, or sexual preference.

IF YOUR DOCTOR OR HMO IS UNHAPPY WITH YOU

Your DOCTOR or HMO may ask Medicaid to remove you from their care, if you:

- do not follow the medical treatment they suggest for you,

- do not make or keep appointments with them, or

- keep going to another DOCTOR without their approval.

Your DOCTOR or HMO must discuss any problems they may have with you first. But if they are still unhappy with you, Medicaid will ask you to choose another DOCTOR or HMO for your medical care.

REMEMBER! YOU MUST CHOOSE A DOCTOR OR AN HMO UNDER MEDICAID. Medicaid can answer questions you have and help you choose. We want you to have the best health care possible.

CALL THE MEDICAID
SPONSOR NUMBER
– NOW! –

256-9344

A WAYNE COUNTY RECIPIENT MAY CALL COLLECT, IF NECESSARY

WRITE DOWN YOUR QUESTIONS BEFORE YOU CALL.

Para participar en el programa de Medicaid usted tiene que escoger un DOCTOR ó una clínica HMO por la cual usted recibirá todos sus servicios médicos. Usted tiene 15 días para informarnos de su selección llamando al número de arriba. Si usted no nos llama dentro de 15 días, el programa de Medicaid le designará un DOCTOR ó una clínica HMO. El nombre y número del teléfono del DOCTOR o la clínica HMO aparecerá en su tarjeta de Medicaid. Si usted no está satisfecha con el DOCTOR o la clínica HMO que se le designó o si necesita más información o asistencia en escoger su DOCTOR o clínica de HMO, por favor llame al mismo numero de arriba.

WRITE YOUR NOTES HERE

Within the limits of the Medical Assistance Program, the Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, political beliefs, or sexual preference.

YOU are enrolled with a DOCTOR under the Medicaid Sponsor Plan

MICHIGAN
DEPARTMENT OF
SOCIAL SERVICES

This pamphlet answers some questions you may have about the plan. Please read it and save it for future use.

WHAT IS THE MEDICAID SPONSOR PLAN?

The Medicaid Sponsor Plan is a new way to provide you with health care. Under the plan, one doctor (your sponsor doctor) is responsible for the medical services and medicines you receive. Your sponsor doctor will make sure you receive all the medical treatment you need.

DO I STILL GET A MEDICAID CARD?

Yes. But now that you are in the sponsor plan, the name of your sponsor doctor is printed on your Medicaid card. You either chose this doctor or a doctor was chosen for you. The name and telephone number of the sponsor doctor each family member must go to is printed under the person's name on the card. Each family member may have a different sponsor doctor under the plan.

WHAT IF "MEDICAID SPONSOR OFFICE" IS PRINTED ON THE MEDICAID CARD?

If a doctor was not chosen for a family member, MEDICAID SPONSOR OFFICE may be printed under that family member's name on the card. You should call the Medicaid Sponsor Office at 256-9344 to select a sponsor doctor for that family member. (The Sponsor Office is open weekdays from 8:00 a.m. to 5:00 p.m.) Even if you do not know which doctor to choose, call the Medicaid Sponsor Office. They will help you make a choice.

If you do **not** choose a sponsor doctor for that family member, when he or she goes to a doctor or hospital for nonemergency treatment, the doctor or hospital must call the Medicaid Sponsor Office for approval. **The doctor or hospital may refuse to provide services until they get approval.**

DOES MY MEDICAID COVERAGE CHANGE UNDER THE PLAN?

No. Medicaid will pay for the same services it does now, but you must go to your sponsor doctor. Your sponsor doctor will provide or authorize your medical care except for certain services which are explained later.

All other Medicaid rules apply. For example:

- a copayment on certain Medicaid covered services,
- a second opinion on certain surgeries, and
- age limits on some services.

Ask your sponsor doctor if you have any questions about your Medicaid coverage.

WHAT DO I DO WHEN I OR A FAMILY MEMBER NEEDS MEDICAL CARE?

You call the telephone number for the sponsor doctor whose name is on your Medicaid card. Remember that different members in your family may have a different sponsor doctor. Be sure to call the sponsor doctor for that family member.

WHAT IF I CALL MY SPONSOR DOCTOR AND NO ONE ANSWERS THE PHONE?

If you need to see a doctor right away, you can go to another doctor or clinic. They will try to contact your sponsor doctor for approval to treat you. If they cannot reach your sponsor doctor, they will call the Medicaid Sponsor Office for approval. Even if they cannot reach the Medicaid Sponsor Office (especially during evenings and weekends), they may still treat you if a delay would be harmful to your health.

If you don't need to see a doctor right away, call the Medicaid Sponsor Office at 256-9344 to report that no one is answering the sponsor doctor's telephone. If your sponsor doctor's telephone line is busy, keep calling until your call is answered.

WHAT IF I NEED EMERGENCY TREATMENT?

If possible, you should always try to call your sponsor doctor first in any emergency. Your sponsor doctor must have 24-hour service under the plan. This means if your sponsor doctor is not available, he or she has arranged for another doctor to see his or her patients.

If it is an emergency (for example, a serious car accident) where a delay may result in permanent harm or loss of life, go to the hospital emergency room. Since your sponsor doctor's name and phone number are on your Medicaid card, the hospital will call your sponsor doctor, if necessary. Your sponsor doctor's approval is not required for emergency care. But you will need your sponsor doctor's approval for any follow-up medical care when the emergency is over.

WHAT ABOUT SPECIAL SERVICES MY SPONSOR DOCTOR CAN'T PROVIDE?

If you need treatment (for example, surgery) that your sponsor doctor does not provide, he or she will have another doctor provide treatment. Medicaid will pay for your medical care by another doctor as long as your sponsor doctor approved it. Your sponsor doctor will tell you to call the other doctor or he or she will call for you. Your sponsor doctor may also give you approval in writing to take with you when you see the other doctor. The other doctor can order x-rays or laboratory tests or write a prescription for medicine.

CAN I CHOOSE THE SPECIALIST OR CONTINUE TO GO TO ANOTHER DOCTOR THAT I GO TO NOW?

You should tell your sponsor doctor about any special doctor you want to go to for medical care. If you still need medical care from that specialist, your sponsor doctor will probably approve it. If your sponsor doctor says no, be sure to ask why. If you disagree with your sponsor doctor, you may ask for a second opinion. (See WHAT IF I'M NOT HAPPY WITH MY SPONSOR DOCTOR.)

DO I NEED APPROVAL (A REFERRAL) FOR ALL SERVICES MY SPONSOR DOCTOR CANNOT PROVIDE?

No. You can have chiropractic, dental, family planning clinic, hearing, podiatric and most vision services without your sponsor doctor's referral. You may also go to Medicaid screening (also called EPSDT for Early and Periodic Screening, Diagnosis and Treatment) if you are under age 21.

WHAT IF I'M NOT HAPPY WITH MY SPONSOR DOCTOR?

If you are not happy with your medical care, you should talk to your sponsor doctor about it. You may ask for another doctor's opinion. Your sponsor doctor must send you to another doctor for a second opinion, if you ask for another opinion.

If a problem with your sponsor doctor continues, call the Medicaid Sponsor Office at 256-9344. They will assist you in solving the problem. If you are still unhappy, you may ask for a new sponsor doctor, an HMO, or a Clinic Plan.

HOW LONG WILL IT TAKE TO CHANGE A SPONSOR DOCTOR OR ENROLL IN AN HMO OR A CLINIC PLAN?

You may begin to go to the new sponsor doctor, an HMO, or a Clinic Plan, when that name appears on your Medicaid card. It may take up to six weeks before the change is made on your Medicaid card.

WHAT IF MY SPONSOR DOCTOR MOVES, DIES, OR RETIRES?

You will be able to choose a new sponsor doctor, an HMO, or a Clinic Plan. Call the Medicaid Sponsor Office at 256-9344 (weekdays between 8:00 a.m. and 5:00 p.m.) to make the change. The Medicaid Sponsor Office will approve your medical care with another doctor until the change is made on your Medicaid card.

WHAT ELSE SHOULD I KNOW ABOUT GETTING MEDICAL CARE UNDER THE MEDICAID SPONSOR PLAN?

All Medicaid recipients have certain rights and responsibilities when seeking medical care. **Your Rights and Responsibilities Under the Medicaid Program** was mailed to you with your Medicaid card. If you cannot find your copy, contact your local worker.

CALL THE MEDICAID SPONSOR OFFICE AT 256-9344 (WEEKDAYS BETWEEN 8:00 A.M. AND 5:00 P.M.) TO ANSWER ANY OTHER QUESTIONS YOU HAVE ABOUT THE MEDICAID SPONSOR PLAN.

Es importante que entienda esta informacion. Si no la entiende o desea información adicional, llame a su Departamento de Servicios Sociales local.

اذا لم تستطع فهم هذا، أو اذا احتجت الى المزيد من المعلومات
فالرجاء الاتصال بمكتب الخدمات الاجتماعية المحلي.

Within the limits of the Medical Assistance Program, the Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, political beliefs, or sexual preference.

DSS Publication 534 (9-83)

NOTICE TO RECIPIENTS IN WAYNE COUNTY
Michigan Department of Social Services

NO PHARMACY COPAYMENT UNDER THE MEDICAID SPONSOR PLAN

Beginning March 1, 1984, you do not need to pay a copayment on drugs if you are enrolled with a Sponsor Doctor.

You can tell if you have a Sponsor Doctor by looking at your Medicaid card. "PHYSICIAN PRIMARY SPONSOR" will be printed on the right-hand side of the card. Your Sponsor Doctor's name and telephone number will also be printed under your name on the card.

"MEDICAL SERVICES ADMINISTRATION" REMOVED FROM THE CARD

Beginning in February, the message "MEDICAL SERVICES ADMINISTRATION," will be removed from Medicaid cards. Sponsor office enrollments were a temporary method which will no longer be used. This means, if you had "MEDICAL SERVICES ADMINISTRATION" on your card, it will be removed. You use the regular card to go to any provider enrolled in the Medicaid program without the Medicaid Sponsor Office approval. Medicaid may contact you in the future to choose a Sponsor Doctor, Health Maintenance Organization (HMO), or a Clinic Plan.

LEARN ABOUT YOUR HEALTH CARE OPTIONS

The Medicaid Sponsor Plan is one way you can get medical care in Wayne County. You may also enroll in an HMO, or Clinic Plan. Currently, HMOs and Clinic Plans in Wayne County do not charge copayments.

If you are interested in receiving information for enrolling with a Sponsor Doctor, an HMO, or a Clinic Plan, please complete the form below and mail it to the address indicated.

NOTE: You may also hear about these health care options through your local worker when your eligibility is being redetermined, your doctor if he or she is a Sponsor Doctor, or through an HMO, or a Clinic Plan.

I would like more information about: (check one or more boxes)

☐ **MEDICAID SPONSOR PLAN** ☐ **HEALTH MAINTENANCE ORGANIZATION** ☐ **CLINIC PLAN**

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE NUMBER _____

Mail to: MEDICAID SPONSOR PLAN
MICHIGAN DEPARTMENT OF SOCIAL SERVICES
P.O. BOX 30037
LANSING, MICHIGAN 48909

Es importante que entienda esta información. Si no la entiende or desea información adicional, llame a su Departamento de Servicios Sociales local.

من المهم جدا أن تفهم هذه المعلومات. اذا كنت لا تفهمها او كنت تريد المزيد من المعلومات فيجب ان تتصل بالمكتب المحلي لدائرة الخدمات الاجتماعية.

Within the limits of the Medical Assistance program, the Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, or political beliefs.

MEDICAID ENROLLMENT REQUEST FOR WAYNE COUNTY
Michigan Department of Social Services

Medicaid is offering three options in medical care for you and your family:

- a doctor under the Medicaid Sponsor Plan,
- a Health Maintenance Organization (HMO), or
- a Clinic Plan. Most clinics are NOT Clinic Plans. If your doctor is in a clinic, call the clinic to see if it is a Clinic Plan.

You choose which option you want to enroll in and complete the attached form. If you need more information on the three options, call 256-9344. You must return the completed form to your caseworker.

The options are designed for you to go to one Sponsor Doctor, an HMO, or a Clinic Plan for most of your medical care.

- You do not have to go to your Sponsor Doctor for chiropractic, dental, family planning clinic, hearing, podiatric, and most vision services.
- You do not have to go to your HMO or Clinic Plan for dental services.

When you need medical care, you must call your Sponsor Doctor, HMO, or Clinic Plan. The name and telephone number of the Sponsor Doctor, HMO, or Clinic Plan will be printed on your Medicaid card.

If you need emergency treatment (for example, because you were in a car accident), and a delay in treatment could result in permanent harm or loss of life, you may go to the hospital emergency room. Since the name and telephone number of your Sponsor Doctor, HMO, or Clinic Plan will be on your Medicaid card, the hospital will call them, if necessary.

If you are unhappy with your Sponsor Doctor, you may change to another Sponsor Doctor, an HMO, or Clinic Plan by calling the Medicaid Sponsor Office at 256-9344. If you are unhappy with your HMO or Clinic Plan, you must contact your HMO or Clinic Plan to disenroll. You will have to choose a Sponsor Doctor, another HMO, or another Clinic Plan.

SPECIAL NOTE:

If you enroll with a Sponsor Doctor you will receive more information from Medicaid about the Medicaid Sponsor Plan. If the doctor you chose is not enrolled as a Sponsor Doctor, Medicaid will contact you to select another doctor, an HMO, or a Clinic Plan.

If you enroll in an HMO or Clinic Plan, the HMO or Clinic Plan will send you more information when you enroll.

MEDICAID ENROLLMENT REQUEST FOR WAYNE COUNTY

Michigan Department of Social Services

Case Name	
Case Number	Date

INSTRUCTIONS:

- Under Medicaid, you must enroll in the Medicaid Sponsor Plan, an HMO, or a Clinic Plan for all your medical care.
  Call 256-9344 if you need more information.
- Your family may enroll with different doctors under the Medicaid Sponsor Plan.
- If you choose an HMO or a Clinic Plan, all family members must enroll in the same HMO or Clinic Plan.
- Complete Section I below if you want to enroll in the Medicaid Sponsor Plan or a Clinic Plan for your family's medical care, OR
- Complete Section II below if you want to enroll in an HMO for your family's medical care.
- It is very important that you enter each recipient ID Number from your Medicaid card. If you do not have a Medicaid card, leave the Recipient ID Number box blank.
- After you complete this form, sign your name below and return this form in the enclosed envelope.

SECTION I: I want to enroll in the Medicaid Sponsor Plan or a Clinic Plan. If you go to a clinic, select a doctor from that clinic. Do NOT enter the clinic name.

List the Name(s) of Each Family Member (Last, First, Middle Initial)	Recipient ID Number	List a Doctor for Each Family Member	DSS Use Only	Doctor's Address	DSS Use Only

SECTION II: I want to enroll in an HMO.

List the Name(s) of Each Family Member (Last, First, Middle Initial)	Recipient ID Number	Enter the Name of the HMO	DSS Use Only	HMO Address	DSS Use Only

Client Address	Phone	SIGN HERE ▶ Client's Signature

DSS-1336 (10-83)

MEDICAID SPONSOR PLAN

You can enroll as my patient

To My Patients on Medicaid:

I am a sponsor doctor in the Medicaid Sponsor Plan. If you live in Wayne County and have Medicaid, you can enroll as my patient in the sponsor plan. This pamphlet explains how to enroll. You also have the option to enroll in an HMO or a Clinic Plan.

If YOU Select Me as Your Sponsor Doctor:

- I agree to have 24-hour service, seven days a week. If I cannot treat you in my office, you will be told where to get treatment. My name and telephone number will be on your Medicaid card. You call that number when you need medical care.
- If you need medical care from another doctor (like a specialist), I will arrange it for you.
- Also, if you enroll in the sponsor plan, you will not have to pay a copayment on pharmacy services.

If you enroll as my patient, you will continue to receive the medical services that you have now. I will help you get all the care you need.

YOU Select a Doctor for Each Family Member:

- You may choose to continue with me as your sponsor doctor, or you may choose another doctor.
- Other family members may choose me, or they may select another doctor.
- But each family member selects only *one* doctor under the plan.

If you would like me to be your sponsor doctor, please fill out the attached form. If there are other family members you are enrolling with another doctor, list them too.

When I Become YOUR Sponsor Doctor:

- My name and telephone number will be printed on your Medicaid card. It will be about six weeks after you mail the form.
- Also, Medicaid will mail a pamphlet to you, explaining more about the sponsor plan. The pamphlet is called, *YOU ARE ENROLLED WITH A DOCTOR UNDER THE MEDICAID SPONSOR PLAN.*

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL
FIRST CLASS PERMIT NO 1312 LANSING, MI

POSTAGE WILL BE PAID BY

Medicaid Sponsor Plan
Michigan Department of Social Services
P.O. Box 30037
Lansing, Michigan 48909

INSTRUCTIONS:

- Make sure you list the name and ID Number for each person. The Recipient ID Numbers are on your Medicaid card.
- After you fill out the form, sign your name on the bottom line.
- Tear the form off the pamphlet carefully. Tape the form closed with the mailing address on the outside.
- Mail it directly to the Medicaid office. The address is already on the form. The postage is paid by Medicaid.

MEDICAID SPONSOR PLAN ENROLLMENT REQUEST
Michigan Department of Social Services

☐ *I wish to enroll with my doctor under the Medicaid Sponsor Plan.* Please list the doctor for each family member below. Use your Medicaid card for the family member names and Recipient ID Numbers. NOTE: If you go to a clinic, select a doctor from that clinic. DO NOT enter the clinic name.

List the Name(s) of Each Family Member (Last, First, Middle Initial)	Recipient ID Number	List a Doctor for Each Family Member	DSS Use Only	Doctor's Address	DSS Use Only

Client Address	Phone	Sign Here ▶ Client's Signature

☐ *I do not wish to enroll at this time.* Please send me more information on:
☐ Medicaid Sponsor Plan ☐ Health Maintenance Organization (HMO) ☐ Clinic Plan

MEDICAID SPONSOR PLAN

Features:

- You select a sponsor doctor to provide or arrange for most of your medical care.
- Family members may select the same doctor or different doctors for each person.
- The name of the doctor you choose will be on your Medicaid card under your name.
- The doctor's phone number will also be on your Medicaid card. You can call this number any time you need medical care, including after office hours. (Calls after regular office hours should be for conditions which cannot wait until the office reopens.)
- You may still see specialists. Your sponsor doctor will review your medical needs with you and determine the need for specialty care. You should tell your sponsor doctor about any specialists you are now seeing.
- You will not have a pharmacy copayment once you are enrolled with a sponsor doctor.
- You do <u>not</u> need your sponsor's authorization for the following types of care:

..Emergency services

..Hearing and speech services

..Most vision services

..Dental services

..Chiropractic services

..Podiatric services

..Family planning clinic services

..EPSDT (Medicaid screening) for children under age 21

- The goal of the Medicaid sponsor plan is to assure that you have a doctor who knows you and is aware of your medical needs. Also, to be sure that your doctor is available to help you when you need help.

If you want to enroll with a sponsor doctor, complete the enrollment form included with these materials. Be sure to read the instructions on the enrollment form. A return envelope has also been provided. Once you are enrolled, you will receive a booklet which will tell you a little more about being enrolled with a sponsor doctor including how to change doctors if you wish. Many doctors are part of the Medicaid sponsor plan. If your doctor is not signed up, we will try to have him or her sign a contract with us. In the meantime, you will receive your card as usual.

If you ever have any problems with the Medicaid sponsor plan or want additional information, call 256-9344 or write:

Medicaid Sponsor Plan
921 West Holmes
Lansing, Michigan 48910

YOUR RIGHTS AND RESPONSIBILITIES UNDER THE MICHIGAN MEDICAID PROGRAM

Michigan Department of Social Services

AS A MEDICAID RECIPIENT YOU HAVE THE RIGHT TO:

- **select your medical providers (doctor, drug store, home health agency, etc.) from those enrolled in the Medicaid Program who are willing to see you.** The Department of Social Services can assist you in finding providers.
- **change a provider or go to another provider for specialty care.** All providers must be enrolled in the Medicaid Program.
- **be treated with dignity and respect by the providers you choose.** All providers must treat you in the same manner as their non-Medicaid patients.
- **immediate treatment, instruction, or referral when you seek emergency or urgent care.**
  - **Emergency care** is needed when any delay in treatment would cause lasting harm or loss of life.
  - **Urgent care** is needed for a condition not likely to cause death or lasting harm, but treatment should not wait for a normally scheduled appointment. The condition may require a hospital setting. Urgent care treatment conditions could include stitching simple cuts or setting simple broken bones like a finger.
- **be seen within a reasonable amount of time when your problem is not an emergency or of an urgent nature.**
- **have all providers explain your treatment so you can understand your care.**
  - You have the right to help plan your care.
  - You have the right to refuse treatment.
- **a second medical opinion about your care.** Note: Medicaid requires you to have a second medical opinion on certain elective surgeries.
- **know which services Medicaid covers.**
  - All providers must inform you **before** a service is provided if it is not covered by Medicaid. *If you still want the service, you must pay for it.*
  - All providers must also follow Medicaid requirements like getting some services (dentures, eyeglasses, hearing aids, etc.) approved by Medicaid before they provide them.
- **know when you must pay an amount for a service.** All providers must bill Medicaid for covered services. They must accept Medicaid's payment as full payment, except when Medicaid requires you to make a partial payment like:
  - **a copayment.** Medicaid will tell you which types of services (dental, medicines, etc.) have a copayment. Your provider will tell you when the copayment must be paid.
  - **a patient-pay amount** for inpatient hospital or long-term-care (e.g., nursing home) services. If you have a patient-pay amount you will be notified by your local worker, or it will be printed on your Medicaid card.
- **have your records kept confidential,** except when those persons (like the Department of Social Services) must review them.
- **appeal any negative action,** like denial of Medicaid eligibility or Medicaid not paying a bill or not authorizing a service. You must appeal within 90 days of the action. Your appeal must be made in writing to your local Department of Social Services or the Bureau of Administrative Hearings, P.O. Box 30041, Lansing, Michigan 48909.
- **review Medicaid information such as:**
  - which medical services provided to you were paid by Medicaid to the providers treating you, or
  - the contract which a doctor signs to enroll in the Medicaid Sponsor Plan.

  Your request must be in writing to the Medicaid Information Division, Medical Services Administration, P.O. Box 30037, Lansing, Michigan 48909. If you request a copy of the information there may be a small charge for each page. **Not all information can be released.**

AS A MEDICAID RECIPIENT YOU HAVE THE RESPONSIBILITY TO:

- **use your Medicaid card wisely.** Seek medical care only when you believe your health and well-being would be threatened if you don't have a medical provider treat you.
  - If you try to obtain services which you don't need, Medicaid may restrict how and when you can use your Medicaid card.
  - If you allow someone else to use your Medicaid card when his/her name is not listed as an eligible person, you could be prosecuted for fraud.
- **show your Medicaid card to all providers BEFORE receiving services.**
  - They must know you have Medicaid to determine if a service is covered.
  - If you don't show them your card, you may be billed instead of Medicaid.
- **treat all providers with dignity and respect.** Learn their office hours, and whom to contact when they are out of the office. Make appointments with all providers for nonemergency care. Cancel your appointments if you cannot keep them. NOTE: Medicaid providers have the choice of whether or not to treat you, just as they have the choice of treating persons not on Medicaid.
- **pay the copayment or patient-pay amount** (if it is required).
- **explain as fully as possible to your provider any medical problem you are having.** And tell the provider all the medical treatment you are receiving, including any medicine you may be taking.
- **cooperate with all providers in collecting any other insurance payments by:**
  - giving your policy numbers. Note: You must also tell your local worker when you have other insurance so the policy numbers will be printed on your Medicaid card. Tell your worker when your insurance coverage is cancelled.
  - signing the insurance forms, when necessary, and
  - returning to all providers any insurance payment sent to you for services they provided.
- **promptly apply for Medicare when you are eligible, including when you are age 65 or older.**

THE ABOVE RIGHTS AND RESPONSIBILITIES APPLY TO ALL MEDICAID RECIPIENTS

If you are enrolled in such plans as a health maintenance organization (HMO), a Clinic Plan (CAP), the Medicaid Sponsor Plan, the Recipient Monitoring Project, or reside in a long-term-care facility, some of your rights and responsibilities may differ. You are informed of any special conditions (like how to choose a provider, or change a provider, and how to file a grievance when you have a problem) as follows:

HMO conditions are on the enrollment form (Form DSS-2003). The HMO must also inform recipients in writing of the HMO conditions when they enroll.

Clinic Plan (CAP) conditions are explained in the enrollment cover letter. The clinic must also inform recipients in writing of the conditions when they enroll.

Medicaid Sponsor Plan conditions are in the Medicaid Sponsor Plan booklet (DSS-524), or you may call (313) 256-9344.

Recipient Monitoring Project conditions are explained by the Department of Social Services in a letter or by a special worker.

Long-term-care facility conditions are on file in the facility.

In accordance with existing laws and administrative rules, all providers must provide services to you without discrimination based on age, race, religion, creed, color, sex, physical or mental handicap, national origin, marital status, political beliefs or sexual preference. However, they must follow the age and sex limits for covered services under the Medicaid Program.

Es importante que entienda esta información. Si no la entiende o desea información adicional, llame a su Departamento de Servicios Sociales local.

من المهم جدا أن تفهم هذه المعلومات. اذا كنت لا تفهمها او كنت تريد المزيد من المعلومات فيجب ان تتصل بالمكتب المحلي لدائرة الخدمات الاجتماعية.

NOTICE TO RECIPIENTS IN WAYNE COUNTY
Michigan Department of Social Services

FACSIMILE

CALL TEL-MED

The TEL-MED TAPE LIBRARY has tape recorded health messages prepared by doctors in your community. There are over 300 tapes available on first aid, birth control, pregnancy, alcohol problems, cancer and other diseases.

TEL-MED also has general information on the Medicaid Sponsor Plan. The tape explains:

* how to get medical care;
* which services do not require a sponsor doctor's authorization;
* how to enroll with a sponsor doctor; and
* how to change sponsor doctors.

CALL TEL-MED at (313) 393-1976. Ask for tape 5009 about the Medicaid Sponsor Plan. If you want to hear a tape for other medical related information, call TEL-MED and tell them the information you want. Call Monday through Friday, 11:00 a.m. to 9:00 p.m., and Saturday, 11:00 a.m. to 7:00 p.m.

SELECT YOUR PLAN FOR HEALTH CARE

If you live in Wayne County, Medicaid offers you 3 health plans: the MEDICAID SPONSOR PLAN, an HMO or a CLINIC PLAN.

How to Enroll

If you know which doctor, HMO or Clinic Plan you would like to enroll with, ask them for an enrollment form. Or, complete the form on the back of this notice, and mail your choice to Medicaid.

NOTE: When you enroll in one of these plans, all family members listed on your Medicaid card must enroll. If you enroll in the MEDICAID SPONSOR PLAN, you can choose different sponsor doctors for different family members. If you enroll in an HMO or CLINIC PLAN, the entire family must enroll in the same HMO or CLINIC PLAN. Family members may choose different doctors within the HMO or CLINIC PLAN after you enroll.

IF YOU NEED MORE INFORMATION BEFORE YOU ENROLL, CHECK THE BOX ON THE FORM FOR THE BOOKLET "SELECT YOUR PLAN FOR HEALTH CARE." We will send you a copy of this booklet to explain the 3 plans.

Es importante que le entienda a esta información. Si no le entiende o desea más información, llame a su oficina local del Departamento de Servicios Sociales.
من المهم جدا أن تفهم هذه المعلومات. اذا كنت لا تفهمها او كنت تريد المزيد من المعلومات فيجب ان تتصل بالمكتب المحلي لدائرة الخدمات الاجتماعية.

DSS-1111-57 (11-84)

Within the limits of the Medical Assistance program, the Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, or political beliefs.

-OVER-

This insert will be mailed to Wayne County recipients with their MA ID cards in January 1985.

Michigan Department of Social Services

☐ I wish to enroll with my doctor under the Medicaid Sponsor Plan. Please list the doctor for each family member below. Use your Medicaid card for the family member names and Recipient ID Numbers. NOTE: If you go to a clinic, select a doctor from that clinic. DO NOT enter the clinic name.

☐ I wish to enroll in an HMO. Please enter the name and address of the HMO below. Use your Medicaid card for the family member names and Recipient ID Numbers. NOTE: If you choose an HMO, you must enroll the entire family in the same HMO.

☐ I wish to enroll in a Clinic Plan. Please enter the name and address of the Clinic Plan below. Use your Medicaid card for the family member names and Recipient ID Numbers. NOTE: If you choose a Clinic Plan, you must enroll the entire family in the same Clinic Plan.

List the Name(s) of Each Family Member (Last, First, Middle Initial)	Recipient ID Number	Enter the Name of a Doctor or HMO or Clinic Plan	Doctor or HMO Address	DSS Use Only

FACSIMILE

Your Address	Phone Number	Case Number

☐ I need more information before I enroll. Please send me a copy of "SELECT YOUR PLAN FOR HEALTH CARE."

Name: _____

Address: _____ CITY: _____ ZIP CODE: _____

MAIL THIS FORM TO: MEDICAID SPONSOR OFFICE
MICHIGAN DEPARTMENT OF SOCIAL SERVICES
P. O. BOX 30037
LANSING, MICHIGAN 48909

WRITE DOWN THE TEL-MED NUMBER,
(313) 393-1976,
BEFORE YOU MAIL THIS FORM.

DSS-1111-57 (11-84) Back

TEL-MED TAPE

PPSP - RECIPIENT

The Medicaid Sponsor Plan is a health care plan in Wayne County. If you live in Wayne County and have Medicaid, you can choose to enroll with a doctor under the Sponsor Plan. You can have all Medicaid covered services under this plan, and you do not have to pay a copayment for pharmacy services. This tape explains the plan and tells you how to enroll.

Over 1,000 doctors are sponsor doctors in Wayne County. You choose one of these doctors to be your sponsor doctor. If the doctor you go to now is a sponsor doctor, you can enroll with him or her under this plan. You may call the doctor's office to ask if your doctor is a sponsor doctor in the Medicaid Sponsor Plan.

Other members in your family who have Medicaid may enroll with the same sponsor doctor or you may choose a different sponsor doctor for them. For example, your children may go to a pediatrician which is a doctor who treats children and you may go to a different sponsor doctor. When you enroll, the name and telephone of each sponsor doctor will be printed under each family member's name on your Medicaid card. It usually takes six weeks before you are enrolled and the sponsor's name is printed on your card.

After you are enrolled, you call your sponsor doctor when you need medical care. Your sponsor doctor agrees to have 24-hour service, seven days a week. Call your sponsor doctor during office hours to make an appointment. If you need medical care after office hours, call the telephone number on your Medicaid card. You will be told where to go for treatment. If you have an emergency, and your medical condition prevents you from calling, you can go to the hospital emergency room. The hospital will provide any necessary emergency treatment.

If you need nonemergency hospital care or other special care, your sponsor doctor will arrange it for you. You cannot use your Medicaid card to go to the hospital or another doctor without your sponsor doctor's approval, except in a medical emergency.

When your sponsor doctor refers you to another doctor for special treatment, the other doctor can provide or arrange for your medical treatment, including x-rays, lab services, or prescription drugs.

You can use your Medicaid card for the following services without getting your sponsor doctor's approval:

- any services ordered by another doctor whom your sponsor doctor referred you to,
- chiropractic services,
- podiatric services,
- hearing and speech services,
- family planning clinic services, and
- most vision services like eyeglasses.

This tape has explained the Medicaid Sponsor Plan. If you have more questions about the plan or if you want to enroll in the plan call the Medicaid Sponsor Office at 256-9344. That number again is 256-9344.

You can also ask your doctor about the sponsor plan. If he or she is a sponsor doctor, there will be enrollment forms in your doctor's office. Your local Department of Social Services office may send you an enrollment form when your Medicaid eligibility needs to be redetermined.

Remember, the sponsor plan is one way to receive medical care in Wayne County. You decide if it is the right plan for you. If you enroll in the plan, Medicaid will send you a pamphlet which explains the plan. It also gives you the Medicaid Sponsor Office telephone number. You can call the Sponsor Office if you decide you want to change sponsor doctors or disenroll. They will make the change, explain your enrollment options, and answer your questions.

SELECT YOUR PLAN For HEALTH CARE

☐ Medicaid Sponsor Plan

☐ HMO

☐ Clinic Plan

YOUR MEDICAL CARE IS IMPORTANT! Medicaid has 3 health plans which offer you complete health care.

This booklet explains each plan. We want you to understand your choices. Select the plan which is best for you and your family.

EACH PLAN OFFERS YOU:

One provider (a doctor or medical group) to provide or arrange all your medical care.

A provider in a location near you.

24-hour service, every day of the year.

Medicaid covered services without copayments or fewer copayments.

All Medicaid covered services, such as:

doctor office visits,
prescription drugs,
lab and x-ray services,
surgery,
inpatient and outpatient hospital services,
specialist services, and
emergency treatment.

Each of these plans provides you with complete medical care at a cost savings to the State of Michigan. This means more medical care may be provided to more people in our State.

READ ABOUT EACH PLAN ...

the Medicaid Sponsor Plan
a Health Maintenance Organization (HMO)
a Clinic Plan

THE CHART ON PAGES 2 AND 3 COMPARES THE PLANS. SELECT THE PLAN THAT IS BEST FOR YOU AND YOUR FAMILY.

COMPARE THE 3 PLANS

THE CHART LISTS MEDICAID COVERED SERVICES. A "YES" INDICATES THAT THE SERVICE IS COVERED UNDER THE PLAN. THE PLANS OFFER ALL SERVICES COVERED UNDER REGULAR MEDICAID. AS WITH REGULAR MEDICAID, SERVICES MAY BE LIMITED BY THE TYPE OF HOSPITAL ROOM, THE AGE OF THE PATIENT, ETC. MOST SERVICES NEED THE SPONSOR DOCTOR'S, HMO's, OR CLINIC PLAN'S APPROVAL.

SERVICE	PLAN 1 MEDICAID SPONSOR PLAN	PLAN 2 HMO	PLAN 3 CLINIC PLAN
Doctor MD/DO Chiropractor Podiatrist Specialist	YES $1.00 Copay $2.00 Copay Referred by Sponsor Doctor	YES No Copay No Copay Referred by HMO	YES No Copay No Copay Referred by Clinic Plan
Maternity (Pregnancy)	YES	YES	YES
Inpatient Hospital Diagnostic Services Surgery Room and Board	YES	YES	YES
Outpatient Hospital Diagnostic Services Emergency Care Surgery	YES	YES	YES
Prescription Drugs	YES No Copay	YES No Copay	YES No Copay
Diagnostic Services Laboratory X-Ray	YES	YES	YES
Medical Supplies	YES	YES	YES
Dental Exams Dentures	*Dental services are not provided under the plan. You use your Medicaid card and go to your dentist. There is a $3.00 copay.*		
Vision Exams Eyeglasses	YES $2.00 Copay	YES No Copay	YES No Copay
Long-Term Care	*If you are admitted into a nursing home, Medicaid will disenroll you from the plan. You will get a new Medicaid card to cover these services.*		
Psychiatric Services	YES	YES	YES
Durable Medical Equipment	YES	YES	YES
Home Health Care Aides Nursing Care Physical Therapy Supplies	YES	YES	YES
Therapies Occupational Physical Speech	YES	YES	YES
Hearing Aids	YES $3.00 Copay	YES No Copay	YES No Copay
Preventive Services Health Screening (EPSDT) Immunizations Family Planning	YES	YES	YES
Ambulance Services	YES	YES	YES
Alcoholism/Drug Abuse Treatment	YES	YES	YES

PLAN 1: MEDICAID SPONSOR PLAN

CHOOSING A SPONSOR DOCTOR

Over 1,200 doctors in Wayne County are in the Medicaid Sponsor Plan. These doctors are called sponsor doctors.

If you select this plan, you choose a sponsor doctor to provide or arrange most of your medical care. Your current doctor may be a sponsor doctor. You can probably go to him or her under this plan. If your doctor is not a sponsor doctor, but you want to enroll with him or her, we will ask your doctor to become a sponsor doctor.

Your whole family may choose the same sponsor doctor or each person may select a different sponsor doctor.

GETTING MEDICAL CARE

The name and telephone number of each sponsor doctor will be printed under each family member's name on your Medicaid card. You call that sponsor doctor when you need medical care.

Your sponsor doctor has agreed to have 24-hour service, every day of the year. You call during office hours to make an appointment. If you need treatment after office hours, call the telephone number on your card. You will be told where to go for treatment. You cannot go to another doctor without your sponsor doctor's approval unless it is a medical emergency.

EMERGENCY CARE

You should always call your sponsor doctor first in any medical emergency. If you cannot call because a delay would cause lasting harm or loss of life, go to the hospital emergency room. The hospital will provide any necessary emergency treatment.

SERVICES WITHOUT A REFERRAL

You may receive these services **without** seeing your sponsor doctor first:

- chiropractic,
- dental,
- family planning clinic,
- hearing and speech,
- medical emergencies,
- podiatric, and
- most vision services.

If you are admitted into a nursing home, Medicaid will disenroll you from this plan. You will get a new Medicaid card for nursing home services and other medical services.

SPECIALIST CARE

Your sponsor doctor will review all your medical needs and help you plan your health care. You may go to another doctor (or specialist) if you require medical care your sponsor doctor cannot provide. The other doctor can then authorize necessary treatment such as prescription drugs, x-ray and laboratory services.

SECOND OPINION

You may ask for another doctor's opinion about your medical care. Your sponsor doctor must refer you to another doctor for a second opinion.

NO COPAYMENT ON PHARMACY SERVICES

You do not have to pay a copayment for pharmacy services under this plan. You continue to pay copayments for the services listed on the chart in this booklet if you are age 21 or older.

ENROLLMENT INFORMATION

To enroll in the Medicaid Sponsor Plan, complete the form given out with this booklet, or the form given out by a sponsor doctor.

You will receive more information on the plan from Medicaid after you enroll.

If you choose a sponsor doctor, but become unhappy with him or her, you can change to another sponsor doctor, an HMO, or a Clinic Plan. You call the telephone number listed below to make any changes under this plan. It takes 2 to 6 weeks for the change to appear on your Medicaid card.

QUESTIONS

Call Medicaid at 256-9344 if you have questions about the Medicaid Sponsor Plan, or write to:

Medicaid Sponsor Plan Information
Michigan Department of Social Services
P.O. Box 30037
Lansing, Michigan 48909

PLAN 2: HEALTH MAINTENANCE ORGANIZATION (HMO)

CHOOSING AN HMO

There are six HMOs in the Wayne County area with over 100 offices to serve you. Each office provides most medical services (including x-rays, lab, and prescription drugs).

You may choose one of the HMOs listed on the next page. Call the main telephone number of the HMO to ask any questions like where their offices are located, etc.

All family members whose names are printed on your Medicaid card must enroll in the same HMO. Each person may choose a different doctor or health provider within the HMO you choose.

GETTING MEDICAL CARE

The HMO will send you an HMO membership card when you enroll. You use the HMO card for all your medical care, except dental. Your HMO will arrange for any hospital care or other special care that is necessary. The HMO will also provide 24-hour service, every day of the year.

You will also receive a "DENTAL ONLY" Medicaid card. You use this card for dental services provided outside the HMO. The name and telephone number of your HMO will be printed on this Medicaid card.

If you are admitted into a nursing home, Medicaid will disenroll you from the plan. You will get a new Medicaid card for nursing home services and other medical services.

EMERGENCY CARE

You will be given a telephone number to call in case of an emergency. If you cannot call because a delay would cause lasting harm or loss of life, go the hospital emergency room. The hospital will contact your HMO.

SPECIALIST CARE

Your HMO doctor will review your medical needs with you and help you plan your health care. You will be referred to another doctor (or specialist) within the HMO, if necessary.

SECOND OPINION

You may ask for a second opinion on your medical care from another doctor within the HMO.

OTHER SERVICES

HMOs offer regular physical exams, and nutrition or food planning services. Some HMOs also have such services as a ride to the HMO for your medical visit. If you are interested in an HMO, call the HMO to find out what special services are offered.

NO COPAYMENTS

HMOs do not charge any copayments. Medicaid does require a copayment on dental services if you are age 21 or older and enrolled in an HMO.

ENROLLMENT INFORMATION

To enroll in an HMO complete the form given out with this booklet, or the form provided by an HMO.

You will receive more information from the HMO after you enroll.

If you become unhappy with the HMO, you can change to another HMO, a Clinic Plan, or a Sponsor Doctor. You contact your HMO to disenroll. It will take 2 to 6 weeks before the change appears on your Medicaid card.

QUESTIONS

Call one the the HMOs listed below if you have any questions:

Comprehensive Health Services of Detroit, Inc.
875-4200

Group Health Plan of Southeast Michigan
879-5600

Health Alliance Plan
876-3450

Independence Health Plan
424-8904

Michigan HMO Plans, Inc.
873-2813

Total Health Care of Detroit, Inc.
833-9735

You can also ask Medicaid by calling 256-9344, or write to:

HMO Information
Michigan Department of Social Services
P.O. Box 30037
Lansing, Michigan 48909

PLAN 3: CLINIC PLAN

CHOOSING A CLINIC PLAN

There are two Clinic Plans located in Wayne County with five offices to serve you. These clinics have a special contract with Medicaid to provide or arrange for all your medical needs (including x-rays, lab, and prescription drugs).

You may choose one of the Clinic Plans listed on the next page. Call the main telephone number of the Clinic Plan to ask any questions like where their offices are located, etc.

All family members whose names are printed on your Medicaid card must enroll in the same Clinic Plan. Family members may choose different doctors within the clinic you choose.

GETTING MEDICAL CARE

When you enroll in a Clinic Plan, you will be issued a Medicaid card with the message "CLINIC PLAN ENROLLEE" printed on the card. The name and telephone number of your clinic will also be printed on the card. You call the clinic at that number when you need medical care.

You may go to your dentist using this Medicaid card. The Clinic Plan will arrange all your other medical care, including any hospital care or other special care that is necessary.

Your Clinic Plan will provide 24-hour service, every day of the year. You call during office hours to make an appointment. If you need treatment after office hours, call the telephone number on your card. You will be told where to go for treatment.

If you are admitted into a nursing home, Medicaid will disenroll you from the plan. You will get a new Medicaid card for nursing home services and other medical services.

EMERGENCY CARE

If you cannot call in a medical emergency because a delay would cause lasting harm or loss of life, go to the hospital emergency room. The hospital will provide any necessary emergency treatment.

SPECIALIST CARE

Your Clinic Plan doctor will review your medical needs with you, and help you plan your health care. You will be referred to another doctor (or specialist) for special medical care, if necessary.

SECOND OPINION

You may ask for a second opinion on your medical care from another doctor within the Clinic Plan.

OTHER SERVICES

Clinic Plans offer routine physical exams and nutritional or food planning services. Some Clinic Plans also have such services as a ride to the clinic for your medical visits. If you are interested in a Clinic Plan, call the clinic to find out what services are offered.

NO COPAYMENTS

Clinic Plans do not charge copayments. Medicaid does require a copayment on dental services if you are age 21 or older and enrolled in Clinic Plan.

ENROLLMENT INFORMATION

To enroll in a Clinic Plan complete the form given out with this booklet, or the form provided by the Clinic Plan.

You will receive more information from the Clinic Plan after you enroll.

If you become unhappy with the Clinic Plan, you can change to another Clinic Plan, an HMO, or a Sponsor Doctor. You contact the Clinic Plan to disenroll. It will take 2 to 6 weeks before the change appears on your Medicaid card.

QUESTIONS

Call one of the Clinic Plans listed below if you have any questions:

CAPE Medical, Inc.
836-1055

Midwest Health Center
581-2600

You can also ask Medicaid by calling 256-9344, or write to:

Clinic Plan Information
Michigan Department of Social Services
P.O. Box 30037
Lansing, Michigan 48909

REMEMBER

We want you to choose the best health plan for you and your family. You may choose the Medicaid Sponsor Plan, an HMO, or a Clinic Plan. Call 256-9344 for more information if you have questions about any of these 3 plans.

WRITE DOWN YOUR QUESTIONS BEFORE YOU CALL.

All Medicaid recipients have certain rights and responsibilities when seeking medical care. Ask your local worker for a copy of **YOUR RIGHTS AND RESPONSIBILITIES UNDER THE MEDICAID PROGRAM.** You may write for a copy:

Medicaid Sponsor Plan Information
Michigan Department of Social Services
Medical Services Administration
P.O. Box 30037
Lansing, Michigan 48909

Within the limits of the Medical Assistance Program, the Department of Social Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, or political beliefs.

Es importante que entienda esta información. Si no la entiende o desea información adicional, llame a su Departmento Servicios Sociales local.

اذا لم تستطع فهم هذا، أو اذا احتجت الى المزيد من المعلومات
فالرجاء الاتصال بمكتب الخدمات الاجتماعية المحلي.

DSS Publication 557 (7-84)

ATTACHMENT 4.1

STATE OF MICHIGAN

WILLIAM G. MILLIKEN, Governor

DEPARTMENT OF SOCIAL SERVICES

300 South Capitol Avenue, P.O. Box 30037, Lansing, Michigan 48909

NOBLE P. KHEDER, Director

Medicaid Sponsor Plan
North End P.O. Box 02040
Detroit, MI 48202

Date January 5, 1983

[redacted]

Dear [redacted]

The Medicaid Sponsor Plan booklet was sent to you recently. You have not responded as directed by the booklet.

YOU WILL BE ASSIGNED TO [redacted]
EFFECTIVE 03/01/83 UNLESS YOU CALL (313) 256-9344 NO LATER THAN 01/19/83.

If we do not hear from you by 01/19/83 you will be assigned to the above Sponsor. As a result, effective 03/01/83 all of your medical services must be authorized by this sponsor. If you do not want this sponsor please call us to make your choice known.

Thank you,

Medicaid Sponsor Plan
(313) 256-9344

Say yes to Michigan!

[redacted] 1

ATTACHMENT 5.1

FM-140 QUARTERLY REPORT OF SERVICES RENDERED TO PPSP ENROLLEES

JAMES J. BLANCHARD, Governor
DEPARTMENT OF SOCIAL SERVICES
[illegible] 48909
AGNES M. MANSOUR (RSM), Director

Dear Doctor:

Enclosed are quarterly reports of services rendered to Medicaid recipients who are enrolled with you under the Physician Primary Sponsor Plan. Reports are generated for recipients with unusual patterns of utilization; that is, utilization which greatly exceeds the average. You will not automatically be sent a report for recipients who have not experienced high utilization. The enclosed reports should assist you in managing the care of your enrolled recipients.

The left hand column notes the types of services received. This list will change depending on which services were rendered. If a type of service is missing, for example, #OPH ER Procedures, it means that the recipient had no outpatient hospital emergency room procedures during the last five quarters. The column headed "THIS QTR" denotes services for the quarter just completed and corresponds to the quarter noted in the heading. Because of billing lag time, these figures may reflect only about half of the services actually provided. Each succeeding quarter becomes more accurate with the column "4 QTRS AGO" being completely accurate. This report was generated based on utilization patterns reflected in the column headed "1 QTR AGO." The figures for the "1 QTR AGO" reflect about 90% of the services actually provided.

This report will give you a feel for the number of different providers and the number of different physicians your enrolled recipients are seeing. The pharmacy detail should also be of interest to you particularly if a number of prescriptions are appearing which you did not authorize. You may wish to consult with your referral physicians if any of the services provided seem excessive in view of the patients' medical needs. The report may be of particular interest in comparing pre-enrollment with post-enrollment patterns (the PPSP enrollment date can be determined from your monthly recipient enrollment list).

If the utilization for a recipient appears questionable, you may request a claim detail report at no charge. This will give you more specific information to assist you in making case management decision. (You may request a detail report for an enrolled recipient for whom a utilization report was not issued but there will be a nominal charge and you should indicate why you are requesting the report.)

Please call Teri Kowalski at (517) 373-1935 if you have any questions about this report or if you wish to request a claim detail report.

Sincerely,

Sally Hetrick

Sally Hetrick, Co-Project Director
Physician Primary Sponsor Plan
Medical Services Administration

MEDICAID POLICY DIV
MSA BUILDING

RUNDATE 02/15/84

MICHIGAN HEALTH AND WELFARE DATA CENTER
PHYSICIAN SPONSOR UTILIZATION REPORT
FOR FOURTH QUARTER, 1983
REPORT NUMBER FM-140

RECIPIENT IDENTIFICATION DATA;
NAME; [redacted]
NUMBER; [redacted]
REGION; 1 COUNTY; 82 SEX; 0 RACE; 1 PAMA PROGRAM CODE; E TITLE V ELIGIBILITY; 0 OTHER MEDICAL INSURANCE; 00 LTCF STATUS; (AGE; 049

FOR SERVICES RENDERED TO DATE AS OF;

NO.	REPORT ITEM/SECTION TITLE	LAST 4 QTRS	THIS QTR	1 QTR AGO	2 QTRS AGO	3 QTRS AGO	4 QTRS AG(
01	MASTER CONTROL SECTION						
01	TOTAL PMTS MEDICAID	2,172.53	385	504	234	7,806	144
02	# DIFFERENT PROVIDERS	15.00	4	3	5	10	5
03	PHYSICIAN PMTS T19	336.76	29	51	74	1,184	36
04	# DIFFERENT PHYSICIANS	7.00	1	1	2	5	2
05	PHYSICIAN AMBULATORY PMTS T19	13.75	11	11	22	11	11
06	# PHYSICIAN VISITS AMBULATORY	1.25	1	1	2	1	1
07	PHYSICIAN OFFICE VISIT PMTST19	13.75	11	11	22	11	11
08	# PHYSICIAN OFFICE VISITS	1.25	1	1	2	1	1
09	# DIFFERENT PHYS OFFICE VISITS	1.25	1	1	2	1	1
10	# OPH ENCOUNTERS GENERAL	0.25	0	0	0	0	1
17	# HOSPITAL DISCHARGES GENERAL	0.25	0	0	0	1	0
19	# IPH DAYS	2.50	0	0	0	10	0
20	INPATIENT HOSPITAL PMTS T19	1,625.86	0	0	0	6,503	0
02	PHARMACEUTICAL SUMMARY						
01	PHARMACY PMTS T19	96.74	100	116	97	89	83
02	# DIFFERENT PHARMACIES	4.00	2	1	1	3	1
03	TOTAL # PRESCRIPTIONS	15.75	13	19	16	14	14
04	# SCHEDULE & OTHER ABUSIVE RX	8.25	8	10*	8	8	7
05	% SCHEDULE & OTHER ABUSIVE RX	52.00	61.00	52.00	50.00	57.00	50.00
06	# SCHEDULE II RX	0.25	0	0	0	1	0
07	# SCHEDULE III RX	0.25	2	0	0	1	0
08	# SCHEDULE IV RX	7.75	5	10	8	6	7
09	# SCHEDULE V RX	0.00	1	0	0	0	0
11	# LAB PROC - PHYSICIAN	0.25	0	1*	0	0	0
12	# LAB PROC - LABORATORY	1.00	0	0	4	0	0
13	# RX - CODEINE COMPOUND	0.25	2	0	0	1	0
14	AVG QTY PER CODEINE COMP RX	25.00	50.00	0.00	0.00	25.00	0.00
15	# RX LIBRIUM/GENERIC EQUIV.	3.75	3	5	4	3	3
16	# RADIOLOGY PROC	2.00	0	0	1	6	1
19	AVG # RX/PHYSICIAN VISIT	12.60	13.00	19.00	8.00	14.00	14.00

PAGE PRINTING SYSTEM- 2118-02

MEDICAL SERVICES ADMIN
DEPT OF SOCIAL SERVICES
921 WEST HOLMES ROAD
LANSING MI 48910

ADDENDUM A PART ONE

METHODOLOGY FOR CALCULATING SPONSOR COST STANDARDS

Average costs for each sponsor's enrolled recipients, whether for rendered, order, or referred services, will be reviewed. Those providers with costs in any single category (in-patient hospital, out-patient hospital, physician/laboratory/radiology, and pharmacy) or in total exceeding the 95th percentile of sponsors may be dropped from the sponsorship program or have their sponsorship fee eliminated or reduced.

Reviews will be initiated after allowing a reasonable time for claims to be submitted. Sponsors will be divided into groups:

Group A - 100 to 500 enrolled recipients, excluding any sponsors included in Group C;

Group B - More than 500 enrolled recipients, excluding any sponsors included in Group C;

Group C - All sponsors who were placed on notice pursuant to Part II of this addendum.

Average costs will be computed for each of these patient types:

Type	Eligibility	Age	Sex
I	ADC	0-15	F
II	ADC	15+	F
III	ADC	0-18	M
IV	ADC	18+	M
V	SSI	0-20	Both
VI	SSI	21+	Both

In addition, the fraction of patients in all reviewed sponsors' caseloads falling in each type will be computed. Each of these fractions will be multiplied by the sponsor's average costs for that recipient type and the products added. This sum is a standardized average cost per sponsored recipient. This process must be repeated for each service category, with the total of these products providing a standardized average total cost per sponsored recipient. When a sponsor has fewer than five enrolled recipients of a particular type, the countywide average cost for that type will be used in the calculation of adjusted total costs.

These standardized averages may then be used to estimate the 95th percentile for each category and for total costs. Any sponsor exceeding this percentile may, at the option of the department, be dropped from the sponsorship program or receive a reduced sponsorship fee, for all of the sponsor's locations or at any individual location retroactive to the beginning of the reviewed

quarter and continuing until all standardized costs fall below the 95th percentile. Recommendations resulting from professional review and a peer review advisory committee, will be considered by the department prior to taking action pursuant to this paragraph.

Sponsors dropped from the sponsorship program may be reinstated after one year with the agreement of both parties, subject to the resolution of any department finding of overpayments to the sponsor.

ADDENDUM A PART TWO OF THE SPONSOR CONTRACT

Criteria (measured during the quarter)	Threshold
a. Office visits per patient with at least one office visit.	2 x CGA
b. Injections per patient with at least one injection.	2 x CGA
c. Therapeutic procedures per patient with at least one therapuetic procedure, excluding injections.	2 x CGA
d. Diagnostic radiology procedures for all patients with a physician encounter.	3 x CGA
e. Pathology procedures per patient with at least one pathology procedure.	4 x CGA
f. Prescriptions per patient with at least one physician encounter (home or office).	2 x CGA
g. Percentage of the physician's total prescriptions during the quarter which were for controlled substances as defined by state and federal law.	50%
h. Percentage of total recipients with a physician encounter who had at least one pathology procedure.	40%
i. Percentage of all patients with at least one physician encounter who had a hospital admission.	20%

If the physician exceeded one or more of the ten thresholds listed above, the physician's Medicaid history for the quarter is reviewed against the following criteria and thresholds.

Criteria (measured during the quarter)	Threshold
a. Average payment per patient with at least one physician encounter.	$100.00
b. Average payment per office service.	$ 50.00
c. Average payment for pathology per patient with at least one pathology service.	$ 75.00
d. Payments for radiology procedures, therapeutic procedures, or pathology procedures as a percentage of total payments.	40%

If the physician exceeds two or more of these thresholds, the department determines, after review by a peer review advisory committee, whether to place the sponsor on notice.

ADDENDUM A PART TWO MODIFICATIONS
FROM JUNE, 1982 TO OCTOBER, 1984

Criteria	Threshold	Contract (6/82)	Contract (10/83 +)	On Notice Letter (present)
i.payments for ordered pathology as a percentage of total payments to the physician.	25%	I	I	NI
j.average number of hospital admissions per all patients with at least one physician encounter.	10%	X	----	----
i.percentage of all patients with at least one physician encounter who had a hospital admission.	20%	----	X	----

I. The Primary Care Physician must submit to DSS as part of patient management:

A. Statement of the kind of services available to the client.

B. What kinds of procedures the sponsor has established for appointments, walkins, and urgent care problems.

C. A written procedure for the client to receive emergency care, which includes instructions for contacting the physician or his/her designee for after hour care.

II. The Primary Care Physician shall assure the maintenance of a clinical record in accordance with accepted professional standards and practices, including:

A. An identification sheet, including name, date of birth or age, sex, next of kin.

B. An initial medical evaluation, including past medical history, personal history, family history and documentation of the results of a base line physical examination or age/sex specific screening.

C. Laboratory and radiological reports.

D. Consultation reports.

E. Physicians and other health professionals' clinical or progress notes documenting the reasons for each encounter or visit.

F. Drug reactions.

G. Allergies.

H. Immunization record.

Each entry must be signed and dated by the provider of the service.

The information contained in the clinical patient record shall be treated as confidential and shall be disclosed only to authorized persons.

An inactive record shall be stored and preserved as an original record or microfilm

The primary care physician shall establish a contingency program to assure the availability of records for a 5 year period in the event of the dissolution of the practice.

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III. The Primary Care Physician shall make available to the recipients the following:

A. Screening on physical examination specific as to age and sex.

B. Preventative health education services and education in the appropriate use of health services and in the contribution each recipient can make to the maintenance of his own health.

C. Information about the services provided by the Primary Care Physician.

The Primary Care Physician shall assure the maintenance of professional staff sufficient to meet the needs of the patient caseload.

IV. DSS shall establish a Quality Assurance Program which will assure a consistent rendering of high quality health care services through the use of monitoring techniques. This must include a formal structure created for the purpose of monitoring, reviewing and evaluating the quality of health services provided and the appropriateness of health care resources utilized including:

A. Standards of care against which the quality of health services can be assessed.

B. Provisions for initiating corrective action where deficiencies in performance are identified.

C. Provisions for re-evaluating previously identified problem areas in which corrective action has been initiated.

DSS shall conduct random medical audits for the purpose of:

A. Assuring the adequacy, maintenance and documentation of clinical patient dates in the clinical records.

B. Evaluating continuity and coordination of patient care.

C. Assessing the quality of health and medical care provided.

The DSS will, for cause, conduct an examination of the Primary Care Physician's facility Quality Assurance Program, and availability and accessibility, evaluate the clinical record system and determine compliance.

Table 1

ATTACHMENT 6.1

PPSP IMPACT ON UTILIZATION AND COSTS:
SELECTED DATA FROM A THREE-YEAR EVALUATION

Financial Impact of Michigan PPSP
Change in Total Medicaid Costs: 1983 to 1984
(Not Reflective of Case Management Fees or Administrative Costs)

Group by Age	1983 Base Costs Per Year/Person	PPSP "Effect" Per Year/Person	PPSP "Effect" as % of Base Year
All Medicaid	$1,147.71	$-147.25	-12.8%
All ADC*	947.81	-197.82	-20.9%
0-14	349.80	+ 62.96	+18.0%
15-21	1,027.59	-284.54	-27.7%
22+	1,718.33	-506.21	-29.5%
All SSI	2,077.65	+ 8.97	+ 0.4%
*All ADC (corrected for 8/86 ADC age distribution)	839.40	-150.97	-18.0%

10/30/86/tj

Table 2

Financial Impact of Michigan PPSP
Change in Total Net Medicaid Costs: 1983 to 1984
(Includes Medical Costs, Case Management Fees and Administrative Costs)

Group by Age	1983 Base Costs Per Year/Person	PPSP "Effect" Per Year/Person	PPSP "Effect" as % of Base Year
All Medicaid	$1,147.71	$-104.26	- 9.1%
All ADC*	947.81	-154.83	-16.3%
0-14	349.80	+105.95	+30.3%
15-21	1,027.59	-241.55	-23.5%
22+	1,718.33	-463.22	-27.0%
All SSI	2,077.65	+ 51.96	+ 2.5%
*All ADC (corrected for 8/86 ADC age distribution)	839.40	-107.98	-12.9%

10/30/86/tj

Table 3

Impact of Michigan PPSP
Change in Total Medicaid Services Used: 1983 to 1984

Group by Age	1983 Base Use: # of Services Billed Per Year/Person	PPSP "Effect" Per Year/Person	PPSP "Effect" as % of Base Year
All Medicaid	40.3	- 5.8	-14.3%
All ADC*	36.1	- 6.1	-16.8%
0-14	16.7	+ 1.4	+ 8.1%
15-21	33.6	- 4.7	-14.0%
22+	62.6	-16.4	-26.2%
All SSI	79.2	- 2.6	- 3.3%
*All ADC (corrected for 8/86 ADC age distribution	32.2	- 4.5	-14.1%

10/30/86/tj

Table 4

Impact of Michigan PPSP
Change in Doctor Visits: 1983 to 1984

Group by Age	1983 Base Use: # of Services Billed Per Year/Person	PPSP "Effect" Per Year/Person	PPSP "Effect" as % of Base Year
All Medicaid	5.57	-0.89	-15.9%
All ADC*	5.23	-0.98	-18.7%
0-14	3.61	+0.05	+ 1.4%
15-21	4.29	-0.47	-11.0%
22+	7.70	-2.48	-32.2%
All SSI	7.29	-0.71	- 9.7%
*All ADC (corrected for 8/86 ADC age distribution	4.86	-0.74	-15.2%

10/30/86/tj

Table 5

Impact of Michigan PPSP
Change in Inpatient Hospital Number of Days: 1983 to 1984

Group by Age	1983 Base Use: # of Services Billed Per Year/Person	PPSP "Effect" Per Year/Person	PPSP "Effect" as % of Base Year
All Medicaid	1.444	-.121	- 8.3%
All ADC*	.947	-.111	-11.7%
0-14	.320	+.113	+35.2%
15-21	1.048	-.036	- 3.2%
22+	1.755	-.432	-24.6%
All SSI	3.734	-.147	- 3.9%
*All ADC (corrected for 8/86 ADC age distribution)	.836	-.063	- 7.5%

10/30/86/tj

Table 6

Impact of Michigan PPSP
Change in Prescriptions: 1983 to 1984

Group by Age	1983 Base Use: # of Services Billed Per Year/Person	PPSP "Effect" Per Year/Person	PPSP "Effect" as % of Base Year
All Medicaid	12.00	-1.33	-11.1%
All ADC*	10.60	-1.76	-16.6%
0-14	4.44	+ .32	+ 7.1%
15-21	8.82	- .13	- 1.5%
22+	18.06	-4.33	-24.0%
All SSI	20.59	-1.86	- 9.0%
*All ADC (corrected for 8/86 ADC age distribution)	8.97	-1.05	-11.7%

10/30/86/tj

Table 7

Impact of Michigan PPSP
Change in X-Rays: 1983 to 1984

Group by Age	1983 Base Use: # of Services Billed Per Year/Person	PPSP "Effect" Per Year/Person	PPSP "Effect" as % of Base Year
All Medicaid	1.88	-.07	- 3.5%
All ADC*	1.65	-.24	-14.5%
0-14	.85	+.17	+19.6%
15-21	1.52	-.17	-11.2%
22+	2.75	-.67	-24.4%
All SSI	2.97	+.41	+13.8%
*All ADC (corrected for 8/86 ADC age distribution)	1.49	-.12	- 8.0%

10/30/86/tj

Table 8

Impact of Michigan PPSP
Change in Ambulatory Services: 1983 to 1984

Group by Age	1983 Base Use: # of Services Billed Per Year/Person	PPSP "Effect" Per Year/Person	PPSP "Effect" as % of Base Year
All Medicaid	40.43	- 5.10	-12.6%
All ADC	33.26	- 5.90	-17.7%
0-14	15.54	+ 1.03	+ 6.6%
15-21	30.02	- 4.04	-13.5%
22+	57.71	-15.57	-27.0%
All SSI	73.74	- 2.28	- 3.1%
*All ADC (corrected for 8/86 ADC age distribution	29.62	- 4.41	-14.9%

10/30/86/tj

Table 9

Impact of Michigan PPSP
Change in Laboratory Tests: 1983 to 1984

Group by Age	1983 Base Use: # of Services Billed Per Year/Person	PPSP "Effect" Per Year/Person	PPSP "Effect" as % of Base Year
All Medicaid	7.30	-2.06	-28.3%
All ADC*	6.82	-2.09	-30.6%
0-14	4.04	+0.32	+ 7.9%
15-21	6.58	-1.52	-23.1%
22+	10.86	-6.14	-56.6%
All SSI	9.74	-1.83	-18.8%
*All ADC (corrected for 8/86 ADC age distribution)	6.35	-1.78	-28.0%

10/30/86/tj

SURVEY OF MEDICAID RECIPIENTS IN PPSP
(RESPONSES IN PERCENTAGES) (1)

	1983 (2)	1984	Difference 1984-1983
Timeframe	1/83-8/83	9/83-8/84	
Number Mailed	854	650	
Number Returned	419	284	
Response Rate	49%	44%	-5%
1.How recipients heard of PPSP			
o Notice in doctor's office	21%	18%	-3%
o Informed by doctor	7	15	+8
o Received solicitation letter from doctor or HMO	14	9	-5
o Friend or relative	14	8	-6
o Informed by DSS worker	14	19	+5
o Assigned by MSA	--	17	--
o Other	3	--	--
o No response	27	14	-13

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(1) Source: Michigan League for Human Services.
(2) The data differ from the MLHS's September 1983 Annual Report because the data were retallied by the Monitoring Project Staff for the purposes of this paper.

ATTACHMENT 6.2 (Continued)

	1983	1984	Difference 1984-1983
2.How recipients chose their sponsor			
a.How recipients got into the plan *			
o called and selected sponsor	59%	13%	---
o called, but desired doctor not on list, assigned to MSA	5	0	---
o did not call, assigned to doctor or MSA	18	0	---
o filled out form at DSS	0	26	---
o received form from doctor	0	26	---
o don't know, doctor's name printed on card	0	4	---
o no response	18	31	---
b.If recipient selected sponsor, how choice was made			
o already seeing doctor	79	71	-8
o called Sponsor Specialist for help	4	--	--
o asked friend or relative	2	4	+2
o responded to solicitation letter from doctor or HMO	1	2	+1
o other	1	8	+7
o no response	12	15	+3

---

* The Monitoring and Evaluation Committee began to use this question, #2a, in July 1983. In May 1984, the written responses were altered to reflect the new recipient enrollment methods. For 2a, here are the relevant timeframes and surveys involved:

	1983	1984
Timeframe	8/83-4/84	5/84-9/84
Number Mailed	500	350
Response (Rate)	190 (38%)	171 (49%)

ATTACHMENT 6.2 (Continued)

	1983	1984	Difference 1984-1983
3.Recipients' use of Sponsor Specialist number*			
o yes	43%	36%	-7%
o no	41	43	+2
o no response	16	8	-8
o didn't know there was a number**	--	13	--
o if yes,			
o assisted	95	--	--
o not assisted	5	--	--
4.Recipients' Access to Care			
a.Travel to doctor			
o Easy	62	65	+3
o Medium	21	20	-1
o Difficult	8	8	0
o No response	9	7	-2
b.Travel time to doctor			
o < 30 minutes	66	69	+3
o > 30 minutes***	27	26	-1
o Don't know	3	--	--
o No response	4	5	+1
c.Transportation to doctor****			
o bus	40	19	-21
o walk	23	18	-5
o drove	15	25	+10
o driven	29	34	+5
o cab	12	4	-8

* Parallel responses to, and use of, this question occurred sporadically. For #3, here are the relevant timeframes and surveys involved:

	1983	1984
Timeframe	1/83-6/83	9/83-8/84
Number Mailed	654	650
Response (Rate)	320 (49%)	284 (44%)

** The Monitoring and Evaluation Committee decided to include this response beginning May 1984.

*** 1983 data include the following division of travel time over 30 minutes:
- o between 30 minutes to one hour = 21%
- o between one to two hours = 6%
- o over two hours = 0.5%

**** Respondees may select more than one response.

ATTACHMENT 6.2 (Continued)

	1983	1984	Difference 1984-1983
5.Recipients' use of medical care			
a.Needed specialist			
o yes	32%	37%	+5%
o no	50	57	+7
o no response	18	6	-12
o if yes, sponsor			
o assisted recipient	75	77	+2
o did not assist recipient	20	23	+3
o no indication	5	0	-5
b.Needed second opinion			
o yes	10	13	+3
o no	83	82	-1
o no response	7	5	-2
o if yes, sponsor			
o assisted recipient	61	61	0
o did not assist recipient	24	33	+9
o no indication	15	6	-9
c.Needed sponsor after hours			
o yes	22	24	+2
o no	74	70	-4
o no response	4	6	+2
o if yes,*			
o doctor or HMO already gave instructions and recipient followed them	16	31	+15
o recipient called doctor or HMO and was given instructions	33	22	-11
o recipient called, no answer:			
o waited for office to reopen	7	9	+2
o went to emergency room	7	15	+8
o recipient did not know where to call:			
o waited for office to reopen	11	6	-5
o went to emergency room	24	16	-8
o other	2	1	-1
d.Needed emergency room care			
o yes	21	26	+5
o no	79	68	-11
o no response	0	6	+6
o if yes,			
o recipient assisted	90	93	+3
o recipient not assisted	6	7	+1
o no indication	4	0	-4

* Respondees may select more than one response.

PPSP IMPACT ON ACCESSIBILITY AND QUALITY OF CARE: SELECTED DATA FROM A THREE-YEAR EVALUATION

TABLE II:-1
Doctor Visit Arrangements

QUESTION	RESPONSES	Percentage of Actual Responses			
		FFS		PPSP	
		Base	Exp	Base	Exp
How long do you usually have to wait between the time you call for an appointment and the date you actually see the doctor?	1. 2 days or less	64.5	59.2	64.3	63.2
	2. 3 days to 2 weeks	30.1	25.2	30.2	29.8
	3. More than 2 weeks	5.4	15.6	5.5	7.0
How long does it take you to get to the place where you usually go for medical care?	1. Less than 15 minutes	36.4	36.2	36.1	37.5
	2. 15-30 minutes	47.4	49.6	47.9	47.2
	3. 31-60 minutes	11.7	9.5	12.3	11.3
	4. More than 60 minutes	4.5	4.7	3.8	3.8
How long do you usually have to wait to see the doctor once you get there?	1. 30 minutes or less	54.5	56.0	51.2	53.8
	2. 31-60 minutes	30.2	30.7	33.6	32.0
	3. More than 1 hour	15.4	13.3	15.2	14.0

Answers to this specific question on the PPSP post-survey questionnaire varied slightly and is incorporated into this table.

TABLE III-2
Doctor Visit

QUESTION	RESPONSES	Percentage of Actual Responses			
		FFS		PPSP	
		Base	Exp	Base	Exp
When was the last time you got medical care?	1. 0-3 months ago	73.8	67.9	69.7	68.8
	2. 4-6 months ago	14.5	15.2	16.8	15.6
	3. 7-9 months ago	3.8	4.8	5.5	5.2
	4. 10-12 months ago	3.0	5.5	3.4	3.8
	5. More than 12 months ago	4.9	6.6	4.6	6.5
Is there one doctor in particular you usually see at the place you go for medical care?	1. Yes	80.3	78.2	80.5	81.3
	2. No	19.7	21.8	19.5	18.7
During the past year, have you felt you needed medical care but did not get it because it is too much trouble or because you didn't like how you are treated?	1. No never.	80.6	83.4	78.9	82.1
	2. Yes, one time	10.7	16.5	12.0	17.8
	3. Yes, more than once	8.7	0.1	9.1	0.1
During the past year, has a doctor or staff person every been rude to you or to your family?	1. Yes, both doctor & staff	3.4	2.6	3.6	2.6
	2. Yes, only a doctor	2.9	3.2	3.3	4.3
	3. Yes, only a staff person	8.2	7.6	9.1	7.5
	4. No, never	85.5	86.5	84.1	85.7
In general, how would you rate your medical care in terms of technical quality (in other words, how good is the diagnosis and treatment you receive)?	1. Excellent	36.9	35.4	36.2	36.0
	2. Good	46.7	47.1	47.5	46.3
	3. Fair	14.8	15.4	15.0	14.6
	4. Poor	1.7	2.2	1.3	3.0

TABLE III-3
NET CHANGE IN SATISFACTION

	All Cases	Non Users	Medium Users	High Users
General Satisfaction with Medical Care	.009	-.165	-.002	.088
Accessibility, Convenience	.002	-.164	.007	.053
Art of Care	-.004	-.066	.001	-.044
Technical Quality of Care	-.089*	-.217*	-.100*	-.291*
Efficacy, Outcomes	.200	-.133	-.043	-.068
Total of Art and Technical Aspects	-.061	-.145	-.060	-.203
Physical Environment	-.027	-.064	-.049	-.120
Availability, Resources	-.049	-.080	-.038	-.100
Satisfaction Total	-.042	-.135	-.043	-.031

* Difference between the change scores for the experimental and control groups is statistically significant at the .05 level.

TABLE III-4
PPSP SPECIFIC QUESTIONS

	Non	Medium	High
A. When you first joined the Medicaid Sponsor Plan, how did you decide which doctor you wanted?			
1. I decided on my own	44 (51.2%)	305 (59.9%)	62 (71.3%)
2. My doctor asked me to sign up	2 (2.3%)	29 (5.7%)	5 (5.7%)
3. DSS picked a doctor for me	20 (23.3%)	95 (18.7%)	8 (9.2%)
4. DSS helped me decide	10 (11.6%)	23 (4.5%)	6 (6.9%)
5. A relative or friend helped me decide	10 (11.6%)	57 (11.2%)	6 (6.9%)
	86 (100%)	509 (100%)	87 (100%)
B. Are you still signed up with the same doctor?			
1. Yes	69 (80.2%)	418 (81.5%)	78 (85.7%)
2. No	14 (16.3%)	79 (15.4%)	11 (12.1%)
3. Not sure	3 (3.5%)	16 (3.1%)	2 (2.2%)
	86 100%	513 100%	91 100%
C. If you are not with the same doctor, why not?			
1. He is no longer in business	2 (9.5%)	12 (11.9%)	1 (5.6%)
2. I changed to a more convenient location	4 (19.0%)	29 (28.7%)	2 (11.1%)
3. I did not like the doctor	0 0	15 (14.9%)	3 (16.7%)
4. My medical situation changed	6 (28.6%)	12 (11.9%)	3 (16.7%)
5. Other	9 (42.9%)	33 (32.7%)	9 (50.0%)
	21 100%	101 100%	18 100%
D. When you first signed up with the Medicaid Sponsor Plan, did you feel you had enough information and time to make a good decision about a doctor for you and your family?			
1. Yes	55 (66.3%)	333 (67.1%)	69 (76.7%)
2. No	19 (22.9%)	105 (21.2%)	13 (14.4%)
3. Not Sure	9 (10.8%)	58 (11.7%)	8 (8.9%)
	83 100%	496 100%	90 100%

E. What did you think would happen if you didn't sign up quickly?

1. Nothing	10 (21.7%)	62 (22.7%)	10 (21.3%)
2. I would lose Medicaid benefits	19 (41.3%)	106 (38.8%)	15 (31.9%)
3. I would have to go to a new doctor	17 (37.0%)	105 (38.5%)	22 (46.8%)
	46 100%	273 100%	47 100%

F. Are you satisfied with the Medicaid Sponsor Plan?

1. Yes	57 (64.8%)	313 (61.3%)	58 (64.4%)
2. No	17 (19.3%)	119 (23.3%)	20 (22.2%)
3. Not Sure	14 (15.9%)	79 (15.5%)	12 (13.3%)
	88 100%	511 100%	90 100%

G. Would you rather stay in the Medicaid Sponsor Plan, or would you rather get a regular Medicaid card?

1. Medicaid Sponsor Plan	24 (27.6%)	171 (33%)	33 (35.9%)
2. Regular Medicaid Card	39 (44.8%)	271 (52.3%)	49 (53.3%)
3. Not Sure	24 (27.6%)	76 (14.7%)	10 (10.9%)

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